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# CANADA LANCET:

A MONTHLY JOURNAL

—OF—

MEDICAL AND SURGICAL SCIENCE,

CRITICISM AND NEWS.

EDITED BY

J. FULTON, M.D., M.R.C.S. ENG., L.R.C.P., LOND.

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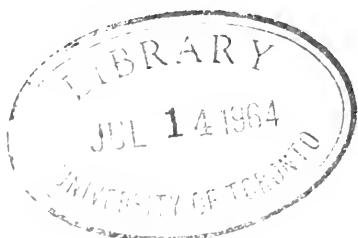
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## Original Communications.

### FIBRINOUS POLYPOID UTERINE TUMOUR—SECONDARY HEMORRHAGE REMOVAL OF TUMOUR.\*

BY A. D. LEITH-NAPIER, M.D. ETC., DUNBAR.

**NARRATION OF CASE.**—Mrs. M., wife of an actor, æt. 22, pale, little, blonde; secundipara; was easily and naturally delivered of a healthy female child on 30th May, 1881. The placenta came easily and was entire; the membranes untorn; in size the placenta seemed rather small, but appeared quite healthy. Mrs. M. originally a weak, fragile woman, of nervous temperament, had been confined of her first child sixteen months prior to the second delivery. She nursed her first baby nine months. Lochia lost colour on fourth day; mother nursed child; milk sufficient; pulse and temperature normal, average 80 and 98°. In consequence of her husband's pecuniary embarrassment at time of her confinement, she had no regular nurse, and possibly exerted herself more than was prudent from the very first. However, she did exceedingly well up to 9th June, (the eleventh day); she rose on that day, but did no house work. In the evening she carried her little boy across the room, and thoroughly washed him; she felt very tired after doing so. Between three and four hours after this bleeding began. I was sent for about 11.30 p.m. On visiting I found my patient reclining in an arm chair, in a profound faint; no pulse at wrist; face pallid as death. The quantity of blood lost was very great; but as she had been sitting up, fully dressed, when hemorrhage commenced, it was impossible to estimate how much, even approximately. The whole of her clothing from below the waist was saturated; the chair, covered with leather cloth, contained a large pool, and from it the blood had streamed over the floor. The faint lasted for

several minutes after my arrival, although on my seeing her she was immediately placed flat on the floor, with her head low. Upon recovering consciousness, the clothing was removed, and she was gently lifted into bed. On examination the vagina was filled with clots, as was also the lower uterine cavity; two fingers could be easily introduced within the os. The uterus felt about the size of a foetal head. By external and internal manipulation many clots were removed, the uterus contracted, and was fixed by a pad and roller. The following was prescribed—

R Ext. Ergotæ fl. ʒi  
Tr. Hamamelis ʒss.  
Aq. ad. ʒij.—M.

Sig. Two teaspoonfuls at once, and one teaspoonful every two or three hours. Cold water cloths were applied to the vulva for an hour and half. After remaining an hour I felt satisfied that bleeding was checked and left. During the night, and next day, several small clots were passed, and about six or eight napkins used. On 11th June two or three cloths were required; on the day following the discharge ceased. Mrs. M. continued to nurse her baby, but was strictly enjoined to maintain the recumbent position in bed. On 13th June, about 2 p.m. I was again sent for. I found the patient sitting up in bed. She was very nervous; bleeding recommenced with much severity about half an hour before. Fully twenty napkins were used; half of the number perfectly soaked. The vagina was cleared of all clots; two fingers introduced *in utero* and some clots, half the size of a hen's egg, removed. The uterus was not nearly so large as on the former occasion. I learned she had only taken her mixture for 48 hours. She had been wholly in bed; but had been "obliged to sit up frequently to attend to baby, as she was fretful." A full dose of ergot was given, and the former mixture ordered to be taken every four hours, also whiskey frequently.

14th June—Clots passed in early morning; discharge very moderate. As her strength was seriously impaired, she was advised to wean her baby.

15th and 16th June—Color of discharge brownish, only one napkin in the twenty-four hours.

17th—Lochia brighter; two napkins through day. 19th—Color almost gone; one napkin in twenty four hours. 22nd—Small quantity of "slimy discharge." 24th—Feeling well; rose; no

\*Read before the Obstetrical Society, Edinburgh, May, 1884.

discharge. 25th—Very slight discharge. 26th—Rose about noon; up two hours; bleeding began necessitating two or three napkins; went to bed, but bleeding continued profusely; after a time it gradually ceased; there was then “a very free clear watery discharge; about 8 p.m. a large blood clot was passed.” I visited about 10 p.m., by this time the bleeding had almost ceased. P.V. examination; after removal of some clots, a pyramidal fixed mass fully occupied the cervix; the uterine tissue was soft, and it was possible to introduce two fingers within the os. The surface of the mass felt rough. The uterus could not be felt distinctly in the hypogastrium. In consequence of the feeble state of the patient, a prolonged examination was deemed inadvisable. The vagina was plugged; full doses of ergot and witchhazel ordered. The handling of the tumour caused little pain; patient stated she “had severe pain in the belly to-day, before and after the bleeding.”

27th—Feeling pretty well. To ascertain the exact nature of the tumour, a sound was used; it passed two and-a-half inches within the uterus. The diagnosis being clear; the tumour was fixed by forceps, and twisted off, with little difficulty. The growth was, roughly, the size of a hen's egg, and was encapsuled in a distinct membrane.

2nd July—Patient exceedingly agitated, on account of a drunken row in lodging-house, but no recurrence of hæmorrhage. The subsequent history contains nothing of note; in fact, from the removal of the tumour she progressed most satisfactorily. On the 13th July she was able to take a longish walk.

REMARKS—The whole subject, and especially the pathology of fibrinous uterine tumours requires so much consideration that I sent the tumour for minute examination to Dr. Woodhead, who after careful observation reported as follows:—“The tumour appears to consist of two factors, a piece of placenta and large masses of coagulated blood. Near the surface of the tumour is an appearance somewhat like that very roughly washed in on the other side. The pink being the placental structure in which are a number of connective tissue, and it appears to me, muscular fibres. The villi are covered with a layer of flattened epithelium and are cut in various directions. In some parts of the section there are numerous cells apparently from the wall of the uterus which are undergoing the

coagulation necrosis, *i. e.* are with the fibrine forming a coarse net work, the coarse strands being formed by fibrin and the periphery of the cell, whilst in the centre of the mesh is frequently seen the nucleus with a small quantity of granular protoplasm. This cannot be accidental, as it occurs at several points and in every specimen I have examined. It is very like the net-work formed in diphtheria. The remainder of the tumour consists simply of coagulated blood which has been thrown out at different times, for in some cases the coagula are much more distinctly seen than in others. Delicate bands of fibrin, form a net work more or less dense and perfect, in which lie the coloured and a few colourless blood corpuscles” Dr. Woodhead, who was most kind in thoroughly examining the tumor, wrote me further that he considered the cells to be “epithelial, not muscular, in character,” “those lining the uterus and probably some of the glands.” I was most anxious to have the opinion of an expert microscopist, as I have found very great confusion in literature regarding the variety to which some of these tumours should be referred.

On macroscopical examination the tumour which was fully as large as a hen's egg, appeared to me more like a small fibro-cystic growth than a fibrinous polyp. I noted that what seemed to have been a cyst was for the most part occupied by a reddish bloody stratum, this stratum evidently having been formed from extravasation of blood within the cyst; the membrane forming the cyst wall was well developed. There had evidently been discharge of part of the contents of the cyst, as the dense coagulated blood and fibrinous appearance, together constituting the main part of the tumour, did not wholly occupy the investing membrane. My rough microscopical examination, before proper hardening, shewed bands of tissue somewhat like fibro-muscular structure, but this has been more exactly described in Dr. Woodhead's report.

Having determined the morbid anatomy of the growth, its pathogenesis next demands notice. The most natural theory is that a growth shewing evidences of placental structure is more or less a product of the placenta. It is well known that poly-poid formations are a frequent result of one or more pieces of placenta having been left *in utero*. It is also equally well known, that at times portions



of retained placenta may sustain existence for a considerable time ; not only existing *in utero* but so to speak persisting in vitality. For example, in one case a lady was sent to the seaside for the recovery of her health and the stoppage of hemorrhage, some weeks after abortion. A more severe attack of bleeding led to an examination ; when a piece of placenta fully the size of a walnut was found lightly held in the cervix ; on its removal bleeding ceased. But in the above case we have more than simple placental structure ; a distinct evidence of cell formation, which cells were evidently derived from the uterus, and also some muscular fibre. The presence of smooth muscular fibres in the placenta has been described by Ecker and Kamenew ; but denied by subsequent inquirers. Stricker states that his own researches demonstrate their presence to be constant in the external layer in the placenta uterina. I think it probable that the muscular fibres here described were uterine. In addition to the placental, there was the aforementioned hemorrhagic portion encapsuled in a distinct membrane. We may assume that the interpretation of the "coagulation necrosis," which Dr. Woodhead remarks on as notable, is, that post-partum the vitality of the growth was checked, and that nature was preparing for its expulsion. So that we may premise that the tumour had an ante-partum existence distinct from the foetal placenta. Small fibrinous coagula intimately blended with the projecting thrombi at the placental insertion, are quite commonly found in the bodies of puerperal women. But larger coagula also, the result of repeated hemorrhages, the size of a walnut, either of a round shape, or flat and lobulated, which may also project into the uterine cavity like a cockscomb, are by no means rare. These cases only are very rare where large fibrinous coagula of a polypoid shape are seated at the normal placental insertion and project with their obtuse end into the cervix or vagina. A fibrinous polypoid of that kind—the free polypus hæmatoma of the uterus (Virchow)—consists of coagulated fibrin including a nucleus of coagulated blood. Polypoid formations, from retained placenta, may undergo further modifications. Upon the pieces of placenta blood may be deposited in the way just mentioned, and a fibrinous polypus is formed with a pedicle of placental tissue, or the retained cotyledon may become bloodless, firm and hard,

and assume a shape corresponding to the uterine cavity. This forms the so called placental polypus.

A few words regarding the changes in effused blood. It may remain liquid for some time, or quickly coagulate. Formation of cysts may take place, not so much in the effused blood as in the surrounding parts. Those which are at first ragged and torn, undergo more or less of inflammation, which ends in the formation of a solidifying blastema ; this fibrillates and passes into the state of more or less perfect fibrous or areolar tissue, and thus forms a capsule or cyst enclosing the now more or less altered blood. Rokitsky describes the later appearance of the lining as like a delicate serous membrane—Hæmatoma. The effused blood may undergo a different kind of change, in consequence of absorption of its watery parts, and become in this way a kind of tumour, termed an hæmatoma, classed with new growth ; but there is no doubt that it is a simple result of hæmorrhage, and this for three reasons—(1) that it presents no higher structure than that of fibrine ; (2) that it is generally devoid of vessels ; (3) that it does not appear to increase by growth in the proper sense of the term. The inner parts ultimately undergo some form of degeneration, while the outer form a fibrous investment. An hæmatoma thus formed (*i. e.* in the substance of new tissues, etc.,) being essentially a fibrinous mass, may undergo certain other changes—cretification, melanic pigmentation, perhaps ossification—(Jones and Sieveking). Some consider it doubtful whether such changes as bone formation, etc., can take place from blood effusion. Without expressing an opinion on this point, I conceive it might be well to retain the name 'hæmatoma' to bloody tumours in loose tissues *e. g.* the vagina, vulva or scalp. As a mere question of pathology the so-called polypoid uterine hæmatoma is diverse from the condition found as a result of rupture of vessels and effusion into sub-mucous connective tissues as found in the one, and beneath the aponeurotic or pericranial layers in the other. No authority, so far as I know, has however observed distinct characteristic cell formation similar to the above described appearances, in a simple hæmatoma. That the tumour was in great measure of this nature is true, but, I think it would be erroneous to regard it as simply a hæmatoma ; and while it is plain that the growth was partly placental, it seems to me equally evident that its de-

velopment was inconsistent with the theory that it was derived from a portion of the main placenta. I think, if we believe in its formation from a placenta succenturiata, which some considerable time before labor had become wholly uterine in its connection, and at one time or other had undergone certain structural changes already referred to, we may best realize the genesis of the polyp. Twenty years ago Professor Hodge, of Pennsylvania, in his "Principles and Practice of Obstetrics," fully described the nature of placenta succenturiata. Dr. Eastlake has also (Obstet. Transact. Lon.) written regarding this anomaly. Schröder writes "sometimes the placenta is divided even in simple pregnancy. Two or more, even seven placenta have been observed; and at the side of a larger, several placenta succenturiata occur. These formations can easily be explained from the development of the membranes—some of the villi of the chorion not inserted at the place of the decidua serotina retain their vessels and enter into vascular communication with the decidua vera. If this does not take place the enlarged villi form the so-called placenta sparia."

POINTS OF PATHOLOGY are here also of interest. Unlike certain allied tumours, no special blood vessels supplied it; this was unnecessary as the growth had been, at first, in the same relation to the uterine circulation as the placenta normally is; but afterwards received a more direct blood supply from a uterine vessel or vessels. In connection with this, the grave bleedings which occurred when the tumour became partially detached can be understood more clearly. Generally the formation resembled that of an aneurismal clot, in which laminæ are formed by the variations in the rate of the coagulation or succession of coagulations, and in the paler portions the definite formation of fibrine gave rise to similar microscopical characters. But the existence of an internal cyst containing clear fluid requires notice. We know, that in not a few cases, cysts of various size are formed on the concave side of the placenta; the connective tissues between the chorion and amnion are raised cyst-like, and are lined by flat epithelium, whilst the placental portion assumes a rough, shaggy appearance, and is covered by fibrinous deposits. These cysts are thin transparent vesicles containing a yellow, or reddish-opaque, thin fluid. It is supposed that they are formed from apoplectic cen-

tres. One writer describing the "fleshy" species of polypi says: "they sometimes contain a cavity filled with fluid resembling mucous or lymph. This variety is however a most likely one to be absorbed during pregnancy." Paget's description of the formation of cysts in loose-textured fibrous tumours is also apposite: "they may be due to a local softening and liquefaction of part of the tumour, with effusion of fluid, or an accumulation of fluid, in the interspaces of the intersecting bands, but in other cases it is more than probable that their production depends on a process of cyst formation." Returning to the present case, it is probable the cyst was adventitious, that is the walls were formed by the condensation of the connective tissue of the part; it is also likely that the cystic fluid may have been serous, derived from the effused blood. If so the external investing membrane must have been, as we would expect, of earlier formation than the small internal cyst. The minute examination of the tumour shows that the different "probable sources" for the formation of uterine polypi, viz.: the connective tissue of the uterus, placental growths, and blood coagula, were all involved; and, as is remarked above, as a consequence of pathological changes in loosely bound together fibro-muscular tissue (?) a cyst may be formed. In further illustration of the benefit of sometimes "thinking twice before you speak once," or in other words making out the morbid anatomy ere you settle your ideas of a case, I may mention that various considerations caused me to regard the polyp as of post-partum formation on the one hand, and as possibly an ante-partum fibro-cystic growth on the other. The theory of post-partum development was suggested by the clinical facts that the placenta was removed with the greatest ease and seemed perfectly entire, there was neither uterine flaccidity nor hemorrhage post-partum; it seemed probable, if the tumour had existed in a condition of latency, it would either have been expelled with the secundines or have given rise to smart bleeding. On the contrary the uterus contracted well, and no symptoms of a growth were then noted. The puerperium was normal; involution seemed natural, the patient having "slimy discharges" for four days antecedent to the first mentioned bleeding. The post-partum formation of the body from a retained blood-clot seemed borne out by the symptoms. As has been already mentioned, poly-

poid growths are not infrequently observed when parts of the placenta are left behind. Schröder perspicuously points out the time at which hæmorrhage is likely to occur—"it may be early, sometimes not till after the first week, more often after the second or third." But the placenta appeared to be wholly removed. I have paid some attention to secondary hemorrhages, and judged the first bleeding to be due to the cause I have described as "imperfect thrombosis," (*Obstetrical Journal*, No. xlvii. Feb. 1877). The patient had unduly exerted herself on the 11th day after delivery, involution having seemed normal previously; it was believed, that as a consequence of the exertion, one of the imperfectly thrombosed veins became partially open, and we might with fair grounds assume the formation of an hæmatoma as a result; theoretically, this having a well established uterine connection might become encapsuled in a layer of fibrinous connective tissue. It is evident that some thrombotic dislodgement actually did occur as shewn by the enormous bleeding. The remedies employed favoured vascular contraction; yet on the 15th day hemorrhage recurred; it was considered probable that the thrombus then became freed, and the separated polypus developed. From this time to the 28th day the blood-oozing was like that of sub-involution, or like surface bleeding of a polyp. The first, and only needful argument against this theory is the morbid anatomy; further, in accepting it, it would be necessary to believe that a polyp with such anatomy could be formed from blood clot in thirteen days. The other theory, viz.: submucous fibroid or fibro-cystic, was based on the ground that while fibrinous polyps are rare, and if present during pregnancy likely to cause abortion, or become absorbed, yet the existence of such has been recorded. Cystic growths are mostly cervical; and developed from the Nabothian glands or utricular follicles. But these follicles also exist near the openings of the Fallopian tubes, in the fundus, and upper part of the body; and granting an abnormal condition of the mucous lining, and a soft dilatable condition of the uterine walls, as was highly probable from the personal history of the patient, it was not impossible to conceive the tumor's formation in one or other of these ways. The examination of the growth put both theories quite out of court. The polypus was antepartum; but the post-partum influences, and the

enlargement it received from secondary hæmorrhage demand attention. I do not think unless there had been undue exertion that the hæmorrhage would have been so serious; in saying so I would point out the existence of the dual causes of bleeding, secondary hemorrhage from the site of the polypus, and also from the imperfect thrombosis of an adjacent vein. To recapitulate, bleeding occurred on the 15th day, I conceive *not* from the vessel which was covered by the tumour, or at any rate from it only partly, most from a neighbouring vein. On the 28th day, when the polypus became loosened, blood gushed from the vein it had previously pressed on, and by covering, plugged; this bleeding was most profuse. The expulsion of the tumour from the uterine cavity was preceded by the discharge of clear watery fluid. After the partial detachment of the growth from the body of the uterus, a large recent blood-clot was expelled; this probably was the result of bleeding from the site of polypoid insertion. A practical point is, that, a firm blood-clot acts as an intra-uterine irritant assists in the production of contractions, and hence aids involution. An ordinary experience in cases of miscarriage of twins at separated periods, is the formation of such a clot. After one foetus has been parted with it is not impossible that the other may reach full term. But this is very unusual; irregular involution or partial uterine atrophy takes place; thrombi are separated from certain veins; large bleedings occur. If appropriate treatment is employed a clot may form and bleeding cease, the uterus enlarges perceptibly thereafter; the same process of hemorrhage, decrease in size, clot formation and increase, may be repeated again and again, until the second foetus is naturally or artificially dislodged. In the case under notice, the large blood clot was probably formed on the 26th June. It is to be observed, that after the escape of this clot, and the descent of the tumour within the cervix, bleeding ceased externally; the cervix was plugged by the polyp; nor was there evident internal hæmorrhage, neither collapse nor increased size of the uterus being experienced. We must recollect that the personal and parturient history of the patient favoured uterine weakness; she was a very pale, fragile, anæmic, little woman, frequently insufficiently nourished; she had barely sixteen months between her confinements, had nursed her first child fully nine months, so that she continued

to nurse two months after she became pregnant. Altogether apart from the polyp, she was a most likely subject for secondary hæmorrhage or subinvolution. With the history given, we may readily suppose how easy it was, with an original abnormality, for the tumour to develope.

THE DIFFERENTIAL DIAGNOSIS is very interesting, as, if my view is correct, we have here a combination of sub-involution, secondary hæmorrhage from irregular or imperfect thrombosis, and a polypoid tumour of placental origin. The early diagnosis pointed to secondary hæmorrhage, as the early puerperium was one of evidently good involution; the lochia lost colour on the 4th day; she was permitted to rise on the 9th day; and it was only after unusual exertion on the 11th day that bleeding began. Yet despite the foregoing observations, there must have been sub-involution, as it was possible to introduce two fingers within the os on the 11th day; the bleeding could not have caused such relaxation; had involution been normal, the os would have been almost closed; my experience agrees with authority that the os is normally closed on the 12th day. The uterus, prior to the removal of clots, was as large as a foetal head; now it seems likely that the faint was most important in arresting the hemorrhage, not the occlusion of the os by a clot; so that we may believe that this bleeding was extremely rapid as well as severe. Several cloths were used on the following day, but only two or three on June 11th; next day there was no discharge. On the evening of 13th bleeding was profuse; the os was still patulous, but the uterus much less in size. The probable cause of this attack was, she had been sitting up in bed, and had neglected her medicine. The subsequent account of slight flow on June 15th and 16th, a little more on the 17th, and its gradual disappearance afterwards indicated involution. The bleeding which was so alarmingly profuse on the 26th, was clearly due to the new source of danger, the partially loosened growth. On this occasion the uterus was not felt in the hypo-gastrium except by bi-manual examination. Such irregular bleedings are met with in chronic inversion, but in acute post-partum inversion the history is different; this condition supervenes suddenly and with it we have hemorrhage and collapse. Partial inversion might occasion similar bleedings, but the organic condition would be explanatory, when the polypus

was forced into the cervix it had much the feel of an inverted uterus. I was strongly reminded of one case I saw some years ago, with Dr. Nellis of Fraserburgh and the late Dr. Fiddes of Aberdeen, of chronic partial inversion; in many respects there was much similitude. The pain in handling an inverted uterus is much more marked; the roughness, said to pertain to inversion as distinct from polypus, was in the foregoing case of little help; the tumour by no means felt smooth; but the encircling band of uterine tissue was more symmetrically circular, and the relations of the vaginal parietes to the cervix more perfectly defined. However it was not until I had cautiously passed a sound  $2\frac{1}{2}$  inches within the uterus, that I felt justified in removal of the tumour. It is all very well to write in one's study of the "clear differences," but in this case at least there was nothing to prove that the body was not an inversion, which had been gradually formed and was eventually protruded, until the sound was used. From prolapsus the tumour was distinct, it occupied the neck, and the neck could be felt. With prolapsus there can be little risk of confusion, even although there should be an opening in the polyp, unless the latter occupies the vagina very fully. I am aware of the possibility of complications of polypus with prolapse and inversion; but there seems here no need of further reference. Nor do I think the "book" differences of polypus from vaginal hernias, cystoceles, or malignant affections require discussion. In chronic cases it is doubtless valuable to bear these in mind, but not with a narration like the above. The intra-uterine situation of the growth obscured diagnosis. Montgomery, fully thirty years ago, wrote "fibrous tumours formed in the substance of the uterus may thence descend, pass through the os, and form an ordinary pediculated polypus in the vagina." To him also we owe the fact that a "large polypus may make its first appearance immediately after delivery. Even with the additional facilities for diagnosis and knowledge we now possess, I think most will agree that until interference is clearly indicated, the policy of non-intervention is wisest. I fancy few would care to dilate and explore a recently parturient uterus, which had ceased bleeding, and judging from the discharges was undergoing involution. Had the polyp not appeared when it did, I would then have explored the uterus more thoroughly. I well know



that in all obscure cases of uterine hemorrhage an exhaustive examination is a hundred-fold less dangerous than is popularly believed. I have known cases where the impregnated uterus submitted to every abuse with impunity, even to an insertion of 10 grs. of lunar caustic to stop a supposed inflammatory condition, and, when profuse bleeding still continued, the artificial dilatation of the os revealed the true cause, a retained foetus and an inflamed chronically enlarged uterus! Viewing our present case retrospectively, one might think had the os been dilated, the whole thing would have been cleared up much sooner; yet, although with the authority of Matthew Duncan to justify us introducing a carbolised exploring hand within the uterus shortly after delivery, and with my personal experience of the benefit of the practice, I would not consider a case of secondary hemorrhage, with os contracted down to two fingers' breadth, a suitable one for this measure, until all others had failed; and that the case diagnostically seemed so far one of this description must be patent. Cervical tears, which have recently—"British Medical Journal, Oct. and Nov. 1881,"—been a subject of discussion, as regards their frequency and treatment, between Montrose Pallen, and Henry Bennet, might have been included in differential diagnosis. These are seldom a consequence of natural labor in such subjects as my patient, and as a matter of fact there were none. Bleeding from varicose veins in the cervico-vaginal region is either tolerably early discovered, or so slight as to require little attention. It seems impossible to misjudge either of these conditions so greatly as to confound them with secondary hemorrhage proceeding from the interior of the uterus.

TREATMENT has in part been touched upon. The primary indications were to check the flow and keep the patient living; the details have been described. Exactly the same treatment is required for secondary hemorrhage and an intra-uterine growth, up to a certain point. As Churchill said "by these means some good may be done, just sufficient perhaps to enable the patient to wait for the descent of the polypus, with rather less risk than if nothing had been done. He however regarded ergot as a beneficial remedy of a special nature. I think the witch-hazel tincture, ordered with ergot, a most useful addition. I have had much satisfaction with this drug in all classes of

uterine hemorrhage; even in malignant disease, it is fully equal, if not superior, to any remedy in restraining bleeding. A combination of hamamelis, with ergot and strychnia, and ferruginous tonics, combined with quinine is all in the way of medicinal agents likely to be of use. The long subject of removal of polypi by means of the various media employed, galvano-cauterics, ecraseurs, ligatures, canula, polypotomes, screws, scissors, or bistouries, need not now occupy us; it was found practicable to twist the tumour off after fixing it firmly; torsion, the simplest method of all, was found easy and satisfactory. There was no bleeding, and the operation was almost painless. The subsequent treatment was simply good nourishment, tonics, and rest. So well did these fulfil their aim, that on the 13th of July the patient was able to take a longish walk without fatigue.

[We are indebted to Dr. Aubrey Husband of Edinburgh, author of *The Students' Hand-Book of Forensic Medicine*, for the above interesting paper.]—ED. LANCET.

#### ABSTRACT OF A CLINICAL LECTURE ON A CASE OF THE "JUVENILE FORM" OF PROGRESSIVE MUSCULAR ATRO- PHY (ERB'S "DYSTROPHIA MUSCU- LARIS PROGRESSIVA").

BY JAMES STEWART, M.D.

Professor of Materia Medica and Therapeutics, McGill University, Montreal; Physician to the Montreal Dispensary; Director of the University Dispensary for Diseases of the Nervous System.

GENTLEMEN,—The patient whom I exhibit to-day, through the kindness of my friend, Dr. Wilkins, presents in a very marked degree all the essential features of a disease which has only recently been described. The case is one of what Erb calls the "Juvenile Form" of progressive muscular atrophy.

The patient is a male, aged 21 years. His occupation, up to the time he was compelled to cease working from his present trouble, was that of a farm laborer. His complaints are, weakness of his back and legs. He first noticed this weakness three and one-half years ago. At that time he experienced difficulty in dragging his body after his feet when getting into a carriage or in ascending a stair. He could, at this time, raise his feet without difficulty, but to move his body, he found it necessary to use his hands to drag

himself along. About two years ago he first noticed that he was very apt to fall, and on attempting to rise from the horizontal position he found it necessary to use his hand to drag himself up. He never suffered from any serious illness. He attributes his present trouble to a fall which he received three and one half years ago. On careful enquiry, however, he acknowledges that for a long time previous to this accident, he disliked ascending a stair, because he found it both difficult and tiresome. Two and one half years ago he received a second injury; on this occasion a weight fell on his head, rendering him insensible for half an hour, and giddy and stupid for several days. His parents are dead, but cause of death is unknown. He has a brother living and in good health. Had no sisters. As far as he knows there has been no similar trouble to his in any of his relations.

*Present Condition.*—You will notice the peculiar gait which he assumes when he walks across the floor: 1st, he walks with his feet far apart; 2nd, he walks on the front part of his feet, the heels being raised from the floor, and 3rd, the gait is of a more or less waddling character. Nothing abnormal can be found in connection with the circulatory, respiratory, digestive or genito-urinary systems. There are no symptoms of any affection of the brain or cranial nerves.

On stripping the patient the marked difference in the size of certain muscular groups is at once noticeable. In the upper extremities, the contrast between the well developed muscles of the fore-arms and the atrophied ones of the upper arms is very striking. The circumference of the thickest part of the upper arms is an inch less than the fore arms. A still greater disproportion exists between the muscles of the thighs and those of the legs, the circumference of either calf being an inch greater than the circumference of either thigh at the thickest part. The following muscles of the upper part of the body are in a state of more or less complete atrophy: The pectoralis major and minor, of each side, are considerably atrophied, especially the costo-sternal portion of the former. The lower half of each trapezius has almost entirely disappeared. There is scarcely a trace left of the rhomboids. The latissimus dorsi of each side is very much atrophied, as is also the whole group of the spinal extensors. The biceps of each

arm is greatly wasted, and what there is left of it is in a state of active contraction, preventing the full extension of the arms. The brachialis anticus of each arm is also in a state of advanced atrophy; the triceps is only slightly affected. The coraco-brachialis, the supra and infra spinati, as well as the deltoids, are normal. None of the muscular groups in the fore-arms or hands have suffered.

In the lower extremities the following muscular groups are in a state of more or less complete atrophy: The glutei of both sides, and the ilio-psoas. The quadriceps of each thigh is more extensively atrophied than any other group in the lower extremities. The peronei of the right side are considerably atrophied, while those of the left side have escaped. The calf muscles are hypertrophied. When the patient is in the erect posture there is marked lordosis. All the atrophied muscles are firm. They are not the seat of any fibrillary twitchings. The patient is quite unable to raise himself from the horizontal to the erect position, even with the aid of his hands. He, however, can accomplish this by getting a support to his chin, and thus using the muscles of the neck to drag his body upwards. The patellar reflex is absent. The plantar reflex is exaggerated. While the cremaster and abdominal are normal on the right side and absent on the left. The epigastric reflex is present, but the scapular is absent. The atrophied muscles do not respond to the faradic current. They are *not*, however, the seat of the degeneration reaction. Sensibility is normal. There is no interference in the vesical or rectal reflexes.

You will at once notice the striking difference there is in the patient before you, and the one\* whose case we enquired into last week, and whom most of you have seen. When comparing these two cases, it is at once observable that we have to do with dissimilar clinical pictures, although they are both frequently described as one and the same disease. The following are the marked points of difference between them: 1st, they differ as to the localization of the atrophy. In the patient affected with the spinal variety of the disease, the atrophy commenced in the small muscles of the hand, in

\* The patient referred to is a man, aged 37, who has the ordinary spinal variety of progressive muscular atrophy. The wasting commenced three years ago in the small muscles of the left hand.

the interossei, thenar and hypo-thenar groups. The wasting is confined to these small muscles. In this patient the atrophy affects the trunk muscles principally, while the hand muscles are perfectly free from any form of wasting. They differ also as to the condition of the affected muscles. In the spinal case they are soft and flabby, while in our patient here they are firm, hard, and have a knotty feeling. In the man previously seen, the atrophied muscles are the seat of fibrillary twitching, while the muscles in this boy's case are free from these fibrillary movements. Another marked difference is that in the case of the spinal form there is neither true nor false hypertrophy of the muscles, while there is here, especially in the calf. Other points of difference are the ages at which they make their appearance. The spinal form is essentially a disease of advanced adult life, while the juvenile form is seldom or never seen after the twentieth year. They are both slowly progressive diseases; the juvenile is, however, much slower than the spinal variety. In the latter the periods of intermission are comparatively short and seldom, while in the former they are long and frequent. They differ also as to the complications that may arise during their course. Last week, when we were examining the patient affected with the spinal form, I pointed out to you that there was marked trembling of his tongue when he protruded it. This is sufficient evidence that there is commencing bulbar paralysis in his case, and is the beginning of a series of symptoms that will before very long lead to a fatal ending. In the patient before you no such complication exists. In all the cases of the juvenile form of progressive muscular atrophy described up to the present, no such complication has existed. Secondary sclerosis of the pyramidal columns is not infrequent as a result of the changes that take place in the spinal form. It does not occur in the juvenile form. When we come to discuss the pathology of the disease, it will then be clear to you why these complications are so frequently present in the one case and never present in the other. Another marked point of difference between these two forms of atrophy is the fact that one is much more amenable to treatment than the other, the juvenile form being much more likely to have a favorable ending than the spinal.

They differ also in their pathology. In speaking

last week of the appearances found post mortem in the spinal variety of the disease, I mentioned that the essential change was a slowly progressive obliteration of the multipolar cells in the anterior horns of grey matter of the spinal cord. The local muscular changes were simple atrophy of the muscular fibres. There is no increase of connective tissue, no deposition of fat, and no hypertrophy of the muscular fibres. Now in the juvenile form the changes are wholly seated in the muscles. The multipolar cells of the anterior horns of grey matter remain free, as do also the peripheral nerves. The muscular changes consists in atrophy of the muscular fibres, with here and there fibres which have undergone hypertrophy. In advanced cases hyperplasia of the connective tissue is very marked, and lying between the connective tissue fibres is seen only a small quantity of muscular fibres in an advanced state of atrophy, which, however, still retain their transverse striation. The most important change is the hyperplasia of the interstitial connective tissue, and next to this is the deposition of a more or less quantity of fat. It is probable that the increase in the muscular fibres is the first phase of the morbid change, and that the later appearing connective tissue hyperplasia gives rise to atrophy of the muscular fibres. These changes, as we will presently discuss, are essentially those found in cases of pseudo-hypertrophic muscular paralysis, and the so-called hereditary form of progressive muscular paralysis. This hereditary form of muscular atrophy has been described by Friedreich and others, but it is essentially the same disease as we are now considering. When the disease is hereditary and sets in about puberty, the muscles affected are those of the upper arms and trunk, while if it sets in during childhood the atrophy is principally confined to the muscles of the lower extremities.

The disease commonly called pseudo-hypertrophic muscular paralysis, differs but little, if at all, from the disease with which the patient before you is affected. Clinically, the only difference appears to be, that in the pseudo-hypertrophic paralysis, we have lipomatosis, while in the juvenile form of muscular atrophy, hypertrophy is not necessarily present, and if present it is true and not false. If this is the only difference it is quite plain that it would be better to describe the juvenile form of muscular atrophy as being sometimes attended

with a true and sometimes with a false hypertrophy of the muscles, rather than describe two separate diseases. Pathologically there is no difference between them. They are both myopathic and *not* neuropathic disorders. All the recent autopsies in cases of pseudo-hypertrophic muscular paralysis agree in the particular that no changes in any portion of the spinal cord are present. The changes found being confined to the muscles and differing in no way (except in a great degree of lipomatosis) from those described as being present in cases of the juvenile form of muscular atrophy. Changes have been described as being found in cases of the pseudo-hypertrophic paralysis in the ganglion cells of the anterior horns, but this was some years ago, and before the much improved methods of the histological examination of nervous tissue were known. Seeing that in a number of recent cases examined by such competent observers as Recklinghausen, Schultze, and Ross, where improved methods were made use of, it follows that little or no value can be attached to the alleged changes found by the observers of even a few years ago.

Erb is a firm believer in the essential identity of these two diseases. Speaking of the juvenile form of muscular atrophy he says \* "there is a particular form of disease of the muscles which consists partly in hypertrophy with subsequent atrophy of the muscular fibres, partly in hyperplasia of the interstitial connective tissue with more or less lipomatosis. Whether the changes in the muscular fibres or in the connective tissue is the primary event, or whether they are simultaneous appearances has not yet been definitely settled. There are no changes in either the peripheral or central nervous system. It is a very chronic and slowly progressive trouble. Clinically the disease is characterized by affecting in the upper part of the body, the pectoral, the trapezii, latississimi dorsi and other shoulder muscles, the muscles of the upper arm, while those of the forearm and hand escape. In the lower part of the body the muscles that suffer are those of the abdomen and the extensors of the back, the muscles of the thigh, calves, and the peroneal group. Cases of this disease in the past have been mostly described as ordinary cases of

progressive muscular atrophy. A few as pseudo-hypertrophic muscular paralysis and hereditary muscular atrophy. If the disease appears in the earliest childhood, and if there is no lipomatosis it is what has been called hereditary muscular atrophy. If there is a high degree of lipomatosis, especially of the lower extremities it is what has been called pseudo-hypertrophic muscular paralysis. These three, hitherto separately named affections, are in reality one and the same disease. It is quite a distinct disease from the spinal form of progressive muscular atrophy." It follows therefore, according to Erb, that there are two distinct forms of progressive muscular atrophy—a neuropathic form and a myopathic form. In the patient whose case we examined into last week, we had a good example of the neuropathic or spinal form. The patient before you now is a good example of the myopathic form. For the former or neuropathic form of the disease Erb proposes the name "*Amyotrophia Spinalis Progressiva*," while for the latter or myopathic variety of the disease he suggests the name "*Dystrophia Muscularis Progressiva*."

TREATMENT.—Before this patient came under the care of Dr. Wilkins, the atrophy had made such progress, that it was hopeless to expect benefit from any form of treatment. Where the disease is however seen early, there is fair grounds for hoping that in a small number of cases, arrest of it or even recovery may follow well directed treatment. As already mentioned, this form of muscular atrophy is more amenable to treatment than the spinal variety. There are very good grounds for believing that both forms would not be so fatal if more systematic and scientific attempts were made in their treatment. Physicians, as a rule, when they diagnose a case of muscular atrophy, pronounce it both "interesting" and "incurable." Seldom is even the attempt made to prevent the further progress of the degeneration. In the present state of the therapeutics of this subject, it is not possible in the very great majority of cases to prevent the progress of the disease. The few cases that have yielded to treatment are a sufficient proof that in the near future we will be much better able to combat this degenerative process. I would strongly advise you in all cases of progressive muscular atrophy, but especially in that form of the disease under consideration, to make persistent efforts to cure. The only therapeutic means of any promise is

\* Erb: Ueber d. juvenile form d. progressiven Muskelatrophie u. ihre Beziehungen zur sogen. Pseudo-hypertrophie d. Muskeln-Deutsches Arch. f. Klin. Med. xxxiv. 5 u. 6 p. 467.



electricity, especially galvanism. The galvanization of the atrophic muscular groups should be performed very gently, otherwise the process may be quickened in place of retarded. It should be continued until it is quite clear that it is useless. Should it be of no effect, faradization of the affected muscles, or even general faradization should be resorted to.

## EPIDEMIC CEREBRO-SPINAL MENINGITIS\*

BY A. WORTHINGTON, M.D., CLINTON, ONT.

I desire to present for your consideration a brief history of an outbreak of epidemic cerebro-spinal meningitis, which took place in the county of Huron early in the year 1872, and in connection therewith some ideas in reference to its treatment. The outbreak occurred at Clinton about the latter part of December, 1871, or the 1st of January, 1872, and was termed in the neighboring towns, "the Clinton malady." It continued in and around Clinton the remaining part of the winter, and the greater part of the following summer. In other parts of the county, cases continued to occur as late as the fall of 1873. The localities visited by this epidemic appeared to be confined principally to the vicinity of streams and lowlands, carrying with it the idea that the specific poison might possibly emanate from that source. The idea was suggested to me by a Toronto medical friend. Mr. John Netton Radcliffe has written more fully on this subject than any other author to which I have had access. He says, "Locality and soil do not exercise any manifest influence over the disease. It has been observed on low grounds, high lands, and on soils of the most varied character indifferently." Sanitary regulations and precautions appeared to have very little influence in this epidemic. The rich and poor were visited alike—the well-fed, well-housed, well-clothed suffered equally with the poorly-fed, housed and clothed. According to Mr. Radcliffe the reverse obtained in certain outbreaks, as that on the Lower Vistula, where the "prosperous classes suffered to a much less extent from the malady than the poor and miserable, who were subjected to privations, and

much foulness of persons, dwellings and atmosphere." Mr. Radcliffe again says, "There is not any constant or common relationship between any insanitary state, and the appearance of the disease. Neither foulness of house and its surroundings, nor the atmosphere, whether from putrid emanations, or from over-crowding, nor impurity of any other kind, has any determinate relation with epidemic cerebro-spinal meningitis." Since the discoveries of Pasteur, Koch and others, it appears quite probable that a germ cause may yet be found for the disease, when some future outbreak provides the opportunity. The attack in many cases was exceedingly violent, causing death in from 24 to 48 hours, death being always preceded by profound coma. Mild cases, which were easily controlled, and terminating in convalescence, were quite numerous. Two cases were observed, which ran 36 and 68 days respectively, ending fatally. The disease was almost invariably ushered in with rigors, more or less severe, and accompanied or followed by pain in the head, sometimes of such a terrific character that the patient continued to cry out until unconsciousness relieved him of sensation. Pain along the spine was noticed as being very severe in only a few cases, but was nearly a constant symptom. Retraction of the head was rarely absent—in some very severe, in others very little. Vomiting was among the early symptoms, but ceased when the disease was fully established. Delirium was a constant attendant in all severe cases; arterial tension was invariably deficient, the pulse being usually abnormally slow, but often frequent towards the end in fatal cases. The temperature in all the cases observed was above normal with one exception. Respiration was irregular; in bad cases, "sighing and labored" according to severity. The treatment, if commenced early, seemed more likely to be satisfactory than if begun later on. Observation has led me to think that epidemic cerebro-spinal meningitis is not necessarily so fatal as is generally supposed. I have, however, never seen any case recover where the patient had passed into a state of stupor for over two to three hours.

In the treatment of epidemic cerebro-spinal meningitis, the removal of all the hair from the head as closely as possible—even shaved—appears to me to be the first essential in all cases of severity. The application of cold to the head is cer-

\* Read before the Ontario Medical Association, June, 1884.

tainly the next (except in cases of collapse or approaching collapse), for without this application, the case may be left to take care of itself, as it certainly will, but it is needful to use the cold cautiously, guarding against the too sedative effect on the already weakened heart, at the same time using sufficient to control and reduce the engorged condition of the vessels of the brain. Blisters to the back of the neck were of great benefit, probably by producing exaggerated circulation near the brain, also along the spine in case of severe pain and spasm of the spinal muscles. Cold was applied in these cases at the same time as the blisters. It appeared to me to be of the utmost importance that cases of this disease should be seen at the earliest possible moment. Treatment delayed beyond two to three hours after the super-vention of stupor, appeared to be useless, as I have not known any case to recover under such conditions. Of medicines, only two were used—aconite and morphia—others might be equally good, but I had not tried them. The two named I had tried and knew what they would do. Aconite controlled the circulation and reduced the temperature, when necessary; morphia seemed to have a marked effect—under its influence the patient became more quiet and got absolute rest; *it appeared to do more, to have a curative effect.* In illustration of this idea, I may mention the case of the housekeeper of Mr. M—, farmer, in the township of Tuckersmith, who had been suffering for several days with spasms of the muscles of the neck and back to that degree, that during the spasms she rested on her head and heels, her back being raised several inches from the bed, she being unconscious while the spasm lasted. The relief, when the spasm was over, was very little, as the retraction of the head was constant and very distressing, and drawn back as much as it could be apparently. When taking nourishment, she could only put some in her mouth, and then push it along down the œsophagus with the thumb and fingers, on account of the muscles of deglutition being stretched to that degree that she was unable to use them. These spasms occurred every 15 or 20 minutes, and lasted two or three. She also had cystitis. A solution of morph. sulph. gr. i, to 3i. of water), was prescribed, a teaspoonful to be given every third hour as long as needed. I saw her first on the 18th May. 1872, and on my

second visit on the 21st, she was quite free from spasms and evidently convalescing. So beneficial was morphia in that terrible disease, that the thought has occurred to me that it *might, like quinine in ague*, yet be found to be a germicide. In sporadic cases I have always pursued the same course of treatment, except, perhaps, in using less morphia, with the same result. I have selected the following four cases, as each was a little different from the other.

CASE 1.—S. S—, æt. 28, cooper, was attacked on the evening of the 23rd March, 1872. I saw him about 8 p.m. Pulse 68, temp. 99, resp. normal; said he felt very sick. I prescribed a febrifuge, and directed a mustard and water foot bath, and to go to bed. About 1 a.m. I was sent for, and found him in a state of stupor, quite unconscious, moaning, and very restless. On enquiry, I was told that in about half an hour after I had left the previous evening, he was seized with a severe chill, which lasted nearly an hour, and during the chill severe pain in the head came on, and so sudden and terrific was it, that his first exclamation was, "Oh! my head!" The pain continued to increase till about 12, when he became unconscious. His pulse was slow, labored and feeble, and his face, arms, hands, body, legs and feet, all were cold, and he was so restless that he could only be kept in one place a few minutes, when he would attempt to rise, perhaps stagger and fall unless held. No heat could be detected in his head, and he uttered no cry, but moaned continuously. It was not easy to know what to do for him. I, however, had his legs from the knees to the ankles, covered with plasters of mustard, and a heated quilt wrapped closely around him, then bottles of hot water and heated bricks kept as closely around him as it was possible to do in his restless condition, and a large blister placed on the back of his neck. As far as possible this course was followed till about 7 a.m., when reaction appeared to be slowly taking place. His movements now became more natural, and he seemed somewhat conscious that there was something wrong with his legs, as he tried to get at them, when he suddenly exclaimed, "Oh! my head!" As he merged towards consciousness, he complained so piteously of his head, that I bled him to about 4 oz., which seemed to ease the pain. I had previously cut the hair from his head, and now began

to apply cold water moderately. His temperature never rose above  $101\frac{1}{2}$ , and his pulse was unnaturally slow, and very compressible, ranging from 60 to 80. Before night his reason had returned. He now complained of pain along the spine (rachialgia) very much, and there was considerable retraction of the head. The spinal pain and tenderness were treated by blistering and cold. On the third day he said he felt sufficiently strong, and was sent by train to Goderich, where Dr. McLean attended him some three or four weeks before he entirely recovered.

CASE 2.—H. S.—, æt. 27, labourer, got intoxicated, and lay out over night, June 30th, 1872. In the morning he felt chilly and had a bad headache, and vomited several times. To relieve his head he put a piece of ice in his hat, and lay down upon the ground in the sun. The pain had increased so much by noon that his mind began to wander and I was sent for. I found him lying on the far side of the bed and he appeared to be in a high fever as his face was very red. I asked him if he could get over near me where I could examine him, and I should say that it took him five minutes to accomplish the task. He afterwards told me that he remembered when I went into the room, but nothing after. Pulse 113, temp.  $103\frac{1}{2}$ F., resp. hurried. He remained delirious for about a week, and during that time there was pretty constant retraction of the head. I had the hair closely cut from his head, and bathed with water in which plenty of ice floated; the first application seemed to produce a shock, but after a few minutes he did not appear to notice it. A blister was applied to the back of the neck and the following prescription given :

R Morph. sulph. grs. ii.  
Ext. aconiti. fl. m. x.  
Aqua                    ℥iv.—M.

Sig.—A teaspoonful every two hours.

His diet was principally milk, no solid food being allowed. The temperature fell in a few hours to  $101\frac{1}{2}$  and did not rise above that again, but came down gradually to, and below normal. The aconite was discontinued after his pulse and temperature were well under control. The morphia was continued till reason returned, then changed to quinine and generous diet.

CASE 3.—Mrs. F., æt. 33, was taken down April 24th, 1872. She had been for several weeks tak-

ing care of her children, who one after the other had taken the disease in a mild form and lastly her husband, who was just recovering, when the attack came, and but for her exhausted condition would probably have been mild. A chill—not very severe—was the first instalment, followed by vomiting, confusion of intellect and delirium. The pulse from the beginning was feeble and very compressible, ranging from 65 to 110 with a marked want of arterial tension. The temperature ranged from  $100\frac{3}{5}$  to  $103\frac{1}{5}$ , being higher in the early stages. Respiration was variable, sometimes hurried, then sighing and irregular. The vomiting ceased on the appearance of delirium. The bowels required but little attention during the attack. On the third day a thick mottled eruption was noticed, purpuric in character, the size being from a pin's head to that of a split pea—the large ones being of a dark purple while the smaller ones were of a reddish cast. Large and small were thoroughly intermingled. Pain in the head, neck and along the cord, especially in the dorsal region, was constant. In a later stage cystitis made its appearance and caused much trouble and anxiety. Still later she suddenly became blind and remained so for about twenty-four hours—this I attributed to nervous exhaustion. She had been taking quinine every two hours, but by some oversight of the nurse it was omitted for about twelve hours during which time she lost her sight. The treatment from the first had to be supporting; aconite was given very cautiously and for a short time only. Morphia was continued through to the end. Her hair was cut off except a little on the front of the head, and cold kept constantly applied. Her neck and the upper part of the spine were repeatedly blistered, and cold applied as constantly as possible. Quinine was given early and continued until she was able to be about the house. Paralysis of the right arm remained for about three months, when sensation and motion were gradually restored. Duration of attack was 50 days.

Mrs. H. B.—, æt. 26, was confined on the 25th April, 1872. Prior to confinement there appeared to be strong evidence of albuminuria, and my suspicions were fully confirmed on making the usual test. Her accouchement passed without trouble, and the kidneys gradually resumed their proper functions. Her progress was satisfactory up to 3rd May, when symptoms of some other

trouble appeared, but what it was I could not tell. There was a slight chill and slight reaction, pain in the head and back, but not severe. There was no vomiting, retraction, nor eruption. Pulse 92, temp. 100½, resp. seemed a little hurried, no abdominal tenderness, the kidneys were secreting the proper quantity of urine, and the albumen had nearly disappeared. There was no puffiness of the face, nor anasarca. The lochia had given no trouble. The pain in the head continued much the same, and on the 5th her mind began to wander occasionally, the pulse became more frequent and feeble, but the temperature did not vary much till towards the end, when it fell to below normal. No lesion of the heart or lungs could be discovered, and I could arrive at no other conclusion than that the poison of the then prevailing epidemic had secured a permanent footing in her system. She gradually sank and died on the 20th May, 25 days from her accouchement. Morphia was given and her neck blistered; tonics and stimulants and the best of nourishment were provided. No cold was used in this case.

REMARKS—The remarkable features in case No. 1 were the severity of the attack, the approaching collapse, and the rapid manner in which he rallied from what appeared to be a hopeless condition. He had uttered no sound but moaning during the five or six hours I was with him, until the exclamation Oh! my head! I confess I am at a loss to explain the rapid changes which took place in this case. In case No. 2 there was the curious fact that the nerves of motion were nearly paralyzed, as it took the patient fully five minutes to move from one side of the bed to the other, but after his hair had been removed, and the ice water applied for some time, he recovered the use of his limbs very fully, for in his delirium, and when his brother was off his guard, he sprang and seized his brother by the throat and was very near strangling him. Case No. 3 was in several points a remarkable one: first, on account of the severity of the attack, which would probably have been mild but for her exhausted condition at the time. Second, the mottled appearance and abundance of the eruption which lay beneath the cuticle. Third, the supervention of cystitis, which helped to complicate the difficulty; fourth, loss of vision, and fifth, paralysis of the right arm. I have placed Case No. 4 in the list of those cases which were certainly epidemic spinal

disease, because I could find no reason to place it anywhere else. The insidious character of the attack would seem to favor the idea that a specific deadly poison had entered the system probably through the same channels which we now charge germ poison with entering to produce puerperal peritonitis.

## TWO CASES OF STRANGULATED FEMORAL HERNIA.

BY J. E. BROUSE, M.D., BROCKVILLE, ONT.

CASE I.—May 13th, 1882, I was sent for to see Mrs M.—, in consultation with Dr. Lane, of Mallorytown, Ont. Her son, who came for me, stated that she had a lump in left groin, that there had been no passage through the bowels for some days past, and that there was frequent vomiting of faecal matter. On arriving, found patient to be a somewhat stout, fresh, bright-looking lady aged 58. She was the mother of a large family, and had always enjoyed good health. Pulse 100, firm, not very compressible, but regular; temp. 101½. She said she had been ruptured for several years, but had not worn a truss, as the tumor was small, gave no trouble, and was easily reducible. Two days previous, however, while lifting, she experienced pain in the part and felt a sickening sensation, and on examining the swelling, found it to be larger than before. Dr. Lane was called in. He had given opium and tried taxis as fully as he dared, but without success. I had her placed on a well cushioned table, and, while under chloroform, had lower extremities elevated and flexed, and endeavored to effect reduction, but was also unsuccessful. The tumor was the size of an ordinary egg, and quite painful. The abdomen was tympanitic. While Dr. Lane continued the anæsthetic, I proceeded to operate, by an incision 2½ inches long in the axis of the tumor. A thick layer of fat necessitated cutting deeply before reaching the sac, which was much inflamed and very dark. After dividing the stricture at the upper and inner angle, found adhesive bands so firmly formed, that, although I separated them as freely as I could, it was impossible to return the sac. It was accordingly opened on a director, exposing a very dark, inflamed knuckle of intes-

tine, which passed readily into the peritoneal cavity. Three sutures, embracing the entire thickness, including the peritoneum, were passed, and dressings of carbolized lint and an oakum pad applied. A hypodermic of morphia was given, and patient placed in bed. No bad symptoms whatever supervened. Flatus passed the second day, and the bowels were freely moved by an enema the fourth day. She made a speedy recovery and is now alive and well.

CASE 2.—Nov. 1st, 1882, was asked to visit Mrs. T—, a lady 67 years of age, who had been taken suddenly ill, Oct. 25th, a full week previous. For several years she had been in bad health and quite feeble, so as to be unable to do anything in the way of house work. Oct. 25th, when going out of the door she slipped, and at once felt sick and experienced pain in the left groin, but did not say anything about it to her sister or family. In a day or two the pain increased, and she began vomiting, the bowels being obstinately constipated. Her sister, to help her on satisfactorily, gave her salts and castor oil, even repeating the dose. I was not sent for until the lapse of seven days, notwithstanding that stercoraceous vomiting had been going on for five days. The woman was greatly exhausted and looked so badly that I almost feared attempting an operation. The tumor was not larger than a walnut, but very painful, and the skin red. Giving her a hypodermic of  $\frac{1}{4}$  gr. morphia, and obtaining the assistance of Dr. Vaux, who gave the chloroform, I tried reduction without avail, and operated at once. The sac appeared almost gangrenous, being nearly black. Without attempting to return it, I slit it up, exposing a small knuckle of intestine, in nearly as bad a state as the sac itself, though saw no actual sloughing. I was in doubt as to the propriety of returning it to the abdomen, but knowing the very great recuperative powers of both the peritoneum and intestine, and believing that, in her exhausted state, an external opening would prove fatal, the bowel was replaced and the wound closed. On Nov. 3rd, flatus passed, and the next day a copious motion of the bowels, which continued daily till her death, Nov. 8th. All tenderness over the abdomen passed away, and all tympanitis, but the nausea and vomiting continued in spite of every effort, and she died of exhaustion the 8th day after the operation.

These cases, especially the second, show the wonderful recuperative powers of the intestinal and peritoneal tissues, and I have no doubt that had Case 2 not been such a feeble person, with strength exhausted by stercoraceous vomiting before, and chloroform vomiting after operating, she would have recovered, the operation itself being a success.

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## Correspondence.

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To the Editor of the CANADA LANCET.

SIR,—I am pleased at the position you assume towards some of the changes proposed by the Ontario Medical Council. Changes made by that body in former times were so frequent that one would need to have the minutes of their proceedings always at hand to assure himself of the legality of his position in almost any given case. It was hoped that the present Council would amend all that, and to a great extent they have done so, and it is therefore much to be regretted that the change of which you very properly disapprove, namely, the compelling of graduates in Arts to pursue a four years' course in medicine, has been made. Our profession is certainly not over-crowded with men of scholarly attainments, and we have always felt that every inducement compatible with a thorough medical course, should be held out to young men about to enter the medical profession, to encourage them to graduate in Arts before commencing their professional studies.

To place a gentleman who has passed through an Arts' course, and taken the degree of B.A., on a par in the matter of study with one who has just quitted the farm or the workshop, is certainly not in accordance with the dictates of experience. Sixteen years' teaching has convinced me that on an average the Bachelor of Arts will acquire as much professional knowledge in three years as one who has not had such a course of training will in four; and besides this, we all know that after the M.D. has been obtained, the man who has also had the training of an Arts' course is much better qualified to fulfil many of the duties which in after life devolve upon the active and respected medical man. I take the average as a rule, and do not ignore exceptions, which are conceded to be the accompaniment of all rules. Apropos of this matter I may

quote a pithy little extract from the *Queen's College Journal* for June—

"It is a significant fact that the Medicals who succeeded this year in taking University prizes are graduates in Arts. The prizes be it noted, were given for essays upon subjects in connection with the medical course. Theorists may maintain that a physician does not require an Arts education, but it is facts and not theories that for the sober-minded are trumpet-tongued. While it would be probably too much to require that every M.D. should be a B.A., as it would be to require that every Reverend should be a B.A., yet as the requirement is being at least generally fulfilled in the latter case, so it should be in the former. The spirit of the times is happily pointing in that direction. Queen's has begun to agitate for a higher standard for matriculation in medicine."

We hope, however, that with the object in view of promoting a higher standard of general education in our profession, such an amendment as the one under discussion will never become a permanent law, unless as a compensating rider they make it compulsory on every medical student to pass a matriculation examination equivalent to that for the degree of B.A.; but this would be asking too much, and hence we ask for a continuance of the old *regime*.

Another change we object to is the imposition of an annual tax of \$5, instead of \$1, upon every registered practitioner while we receive no corresponding value. Raising money in this manner for the purpose of stocking the rooms in which the Medical Council meet with a library and museum, does certainly not commend itself to the profession at large, inasmuch as our representatives are sent to Toronto for the purpose of legislating in behalf of our professional interests, and not for the purpose of refreshing their minds by perusing the tomes of a library and examining the specimens in a museum. We have been waiting patiently year after year to see some legislation that would bring under control the manufacture and sale of the many nostrums that flood our land; that would restrict or prohibit the misleading advertisements of shameless adventurers; that would enforce a proper code of ethics amongst qualified practitioners, and provide for the disciplining of those who habitually transgress it; to restrain druggists from their almost universal custom of prescribing for patients, etc. etc.; but we have hitherto waited in vain. Until our Council can show us some practical work, beyond the modifying of curricula, and the transferring of the subjects of medical study from one part of the course to another, and back again, I for one most emphatically protest against

paying any more than we pay at the present time. Let them turn their attention to clearing away some of the impostures and annoyances to which both the laity and the profession are subjected, and then we will hail the labors of the Medical Council with gladness and bid them God-speed in their laudable efforts.

Yours truly,

THOS. R. DUPUIS.

Kingston, July, 1884.

## Reports of Societies.

### ONTARIO BOARD OF HEALTH.

The third quarterly meeting of the Provincial Board of Health was held in Toronto on the 31st of July, Dr. C. W. Covernton in the chair. The fore part of the day was taken up with matters of routine, the secretary's report of work done, etc. Replies were read to the circulars sent out to local boards, some of which showed considerable interest in sanitary matters, while others were the reverse of what should be expected. Pamphlets on cholera were distributed in large numbers. Correspondence had passed between the Board and the Dominion Government regarding the precautions which were being taken by the quarantine officers at ports of entry to prevent the introduction of infectious diseases. The replies, though courteous enough, were far from satisfactory.

The chairman read a report on epidemics, in which he alluded to the absorptive powers of milk, and the dangers arising therefrom. He gave instances of outbreaks of typhoid fever and other infectious diseases which had been directly traceable to this source.

The secretary was instructed to communicate with the railway authorities, recommending that they provide dry earth closets on all cars.

The second day's session began at half-past ten a.m. The secretary read a letter from Dr. Brown, of Galt, stating that the manufactories on the east side of the Grand river were making offensive deposits in that river, and stating that he had taken steps to force the owners to stop the nuisance. He wished to know if the Board would support him in this action.

On motion of Dr. Cassidy, a Committee was appointed to enquire into the evils of baby farming, and suggest a remedy.

The Board then went into Committee of the Whole to consider the report which was to be handed to the Lieutenant-Governor concerning the precautions which, in the opinion of the Board, should be taken in case cholera should break out

here. The following is the substance of the regulations which were recommended :

As soon as danger has become imminent, the Board shall ask for a grant to be set apart by the Government sufficient to enable the Board to pay a medical executive officer in each town in the Province, and to meet the expenses incurred in taking precautions against the spread of the epidemic. These medical health officers will be executive officers of the Board ; and where it is found possible, the officer of the Local Board of Health shall be chosen for the position. He shall report to and act in accordance with the instructions of the Board.

On the approach of the first case of cholera the medical health officer shall at once remove it to the isolation hospital, and shall take every measure for the disinfection of linen and clothing worn by sufferers, and if necessary destroy them. He shall be careful to destroy any food which has begun to decay.

In regard to the quarantine stations which shall be provided by the local Boards of Health, all persons who may have been exposed to the infection shall be detained until such time as the period of incubation shall have elapsed, and shall be permitted to go only on being thoroughly disinfected by fumigation.

If any municipality be a port of entry from infected districts, the medical executive officer shall make a strict inspection of said vessel before any passengers, luggage, or freight from it be allowed to land ; and where any affected or exposed persons are found on board they shall be dealt with in the manner above indicated. And further all personal effects or other exposed luggage or freight shall be thoroughly disinfected before being landed.

Wherever cholera exists in any Province or State adjoining Ontario, from which railways enter the Province, the medical executive officer shall be given the full powers of a quarantine officer as far as can be exercised under the provisions of municipal or provincial laws. He shall examine all trains suspected of containing cholera, making thorough disinfection. The medical executive officer may by arrangement with the railways, board the trains when some miles outside the Province, in order to avoid unnecessary detention of trains.

Should cholera appear in this Province or in any Province or State adjoining this Province, the medical health authorities shall, under the direction of the Provincial Board of Health, carry out the recommendations contained in the pamphlet No. 14, issued by the Board.

Dr. Oldright then read a report on the prevalence of typhoid fever at the Kingston Insane Asylum. He had found the ventilation and drainage defective and the water tainted.

A letter was received from Mr. Prust, of Hali-burton, complaining of the nuisance of sawdust deposits in the lake. The chairman and secretary will take steps to assist the local Board in abating the nuisance.

In the evening session, Dr. Yeomans presided in the absence of Dr. Covernton. Upon enquiry, it was found that many municipalities had not formed local Boards under the Act, and the secretary was instructed to notify the clerks of the municipalities, and that in case the law was not complied with, the Provincial Board would appoint members of the Local Board, as provided for in the Provincial Health Act.

The secretary was also instructed to inquire through the proper official channel what precautions the Dominion and other Provincial authorities were taking to prevent the introduction and spread of cholera and other zymotic diseases.

Dr. Cassidy and Dr. Bryce were appointed delegates to the Sanitary Conference at Washington, and Dr. Covernton and Dr. Oldright to the British Association for the Advancement of Science, and the Canadian Sanitary Association at Montreal. The chairman will appoint a deputation, including himself, to the meeting of the American Public Health Association at St. Louis in October.

#### THE NEW BRUNSWICK MEDICAL SOCIETY.

The fourth annual meeting of the New Brunswick Medical Society was held in St. John, on the 17th and 18th of July. The attendance was large, there being fully forty members present. Hon. Dr. Vail, the president, occupied the chair. Dr. Musgrove, in the absence of Dr. Duncan, was appointed secretary *pro tem*.

The president made a brief address, expressing his pleasure at seeing so many members present, and describing the objects for which the society was formed and the advantages of belonging to it.

A communication was read from the W. C. T. U. referring to the increase of intemperance, caused to a certain degree by the administration of alcoholic stimulants by physicians, and calling upon the society to unite with them in suppressing intemperance. The communication was filed.

Dr. F. A. Nevers, the treasurer, reported that after paying the bills there remained on hand \$87.05.

The committee appointed to consider the feasibility of publishing a *Journal* reported in favor of the scheme, the publication to be entitled, *Medical and Surgical Journal* of the N. B. Medical Society. Messrs. J. & A. McMillan's offer to publish the work quarterly, 200 copies, twenty-four pages, without charge, on consideration that they receive the benefit of all advertising, was recommended for acceptance. The vote on its adoption stood 19 to 15. Drs. J. D. White, S. Z. Earle and J. T.



Steeves were appointed a committee to superintend the publication of the journal, and Dr. L. C. Allison was appointed editor.

The following officers of the society were elected: President, Dr. Thomas Walker; 1st Vice-President, Dr. E. M. Patterson; 2nd Vice-President, Dr. George Taylor; Secretary, Dr. T. W. Musgrove; Treasurer, Dr. D. E. Berryman; Corresponding Secretary, Dr. W. F. Coleman; Trustees, Drs. Coleman, D. E. Berryman, Daniel; Council, Drs. Steeves, Earle, Vail, Moore, Christie.

Dr. Grant, of Ottawa, who was present, was invited to a seat on the platform, and addressed the society. He alluded to the energy, activity and ability displayed by the profession in New Brunswick, and was pleased to see so large an attendance. He also referred, among other things, to the excellent summer resorts in this part of the Dominion, and concluded by wishing the society many years of success.

In the evening there was a very pleasant conversation, at which a large number of ladies were present. Dr. Vail presided. A paper on Sanitary Science was read by Dr. Bayard. Music and short addresses by some of the medical gentlemen present, enlivened the proceedings. Refreshments were served during the evening.

#### SECOND DAY.

The society met at 10 a.m., Dr. Walker in the chair.

After routine, Dr. Gray read an excellent paper on "Uterine Fibroids," in which he gave a number of cases in his own experience. An interesting discussion followed.

Dr. Moore then read a paper on the treatment of "Hydrocele" by iodine and carbolic acid.

Dr. S. Z. Earle thought that these remedies would not effect a permanent cure. He related a case where the disease had returned after twenty-two years.

Dr. Harrison agreed with Dr. Earle. A similar instance had come under his notice.

Dr. Frank Nevers related a case in which he had used iodine, U. S. P. At first he did not think that his patient would rally, but subsequently he came round all right. In future he would be inclined to use carbolic acid.

Dr. McFarland read an interesting paper on "Conservative Surgery in Compound Fractures," and described the mode of treatment he adopted. One of his patients, whose leg had been badly mangled, was shown, and the limb examined.

Dr. Moore and others expressed satisfaction with the paper and hoped that it would lead medical men to be more careful in dealing with fractures.

Dr. James Christie said there were cases which terminate well, and there were other cases in which the patient dies. It was often a serious question,

whether we should amputate or not. In the present case a good constitution had largely been the cause of the patient's recovery.

Dr. Nevers related a case in which the patient had died by endeavoring to save her limb.

Dr. Coleman stated that the mortality in amputation of the thigh was 63 per cent.

Dr. Coleman then read a carefully prepared paper on "Some Points in the Diagnosis and Treatment of Diseases of the Eye." In the discussion which followed, the paper was warmly commended, and regret was expressed at the rumor that Dr. Coleman intended to leave St. John.

Dr. James Christie read a paper on "Amputation after Recent Injury," citing a case or two in support of his contentions.

At the afternoon meeting Dr. Musgrove read a paper on "The Proper Use of Alcohol as a Medicine," taking strong ground against its use, except in the way arsenic, opium, or any other poison is used. In the discussion which followed, the usual view prevailed, that competent medical men were the best judges of when and how to prescribe alcohol. The medical profession is opposed to the use of alcohol except in case of absolute necessity.

Last, but not least, was an admirable paper on "The Germ Theory in Disease," by Dr. J. P. McInerney, of Portland. Drs. Barker, Coleman and Grant spoke in high terms of the paper.

The next annual meeting of the society will be held in Fredericton, and Drs. Brown, Currie, Coburn and Barker were appointed to make arrangements.

#### HURON MEDICAL ASSOCIATION.

The regular meeting of the Huron Medical Association was held in Clinton on the 8th July, Dr. Williams, president, in the chair.

Dr. Hyndman, of Exeter, presented a case of hemoptysis, recurring since the 7th May, quite frequently. The patient last fall had an attack of bronchitis from which he apparently recovered. On careful examination the normal respiratory murmur was heard, except at one point about two inches in diameter and about the same distance below the left clavicle. His general appearance is one of fairly good health. There can, however, be little doubt that he has incipient phthisis.

Dr. Elliott presented a boy four years of age, who had been attacked with inflammation of the left arm below the shoulder, resulting in an abscess. Another soon formed at the joint, from which a quantity of pus was evacuated. The head of the scapula was found carious and the entire epiphysis removed at different times. The result was recovery with partial ankylosis. A little mobility of the joint existed which would likely increase.



Dr. Campbell, of Seaforth, reported a case of Pott's curvature of the spine, in a lady of 59 years, in which entire recovery took place after seven plaster of Paris jackets had been used. He also reported a case of pleuro-pneumonia ending in empyema. Six pints of healthy pus were taken by aspiration, and fourteen days after eight pints of very fetid pus were removed by free incision, and the cavity washed out three or four times a day with carbolic lotion.

Dr. Worthington presented a case of rodent ulcer, situated at the outer angle of the left lower eyelid. The treatment advised was scraping with Volkman's spoon and cauterizing with chloride of zinc solution. He also presented a case of congenital defect of the spinal medulla, and probably of the left frontal lobe of the brain. The patient is six years of age, and cannot walk, but is making some effort to do so, and also to talk. When an infant he had no control over the motions of his head whatever. When attempting to walk he is bent very much forward and both arms extended. There is a want of co-ordination which in time seems likely to be overcome. He has perfect control of his passages.

Drs. Smith and Nichol are to prepare papers for the next meeting.

#### BATHURST AND RIDEAU MEDICAL ASSOCIATION.

The eleventh annual meeting of the Bathurst and Rideau Medical Association was held at Carleton Place, on the 9th of July. There was a large attendance of members present, Dr. Cranston, President, in the chair. The Secretary's minutes and Treasurer's report were read and adopted. The latter announced that as there were sufficient funds on hand no levy would be made this year upon the members.

The President, in his annual address, alluded to the work done in the Medical Council, referring particularly to the proposed changes in the Medical Act. A discussion followed, in which many took part; the increase of the annual fee was objected to, especially the payment of a life fee which, it was contended, would only encourage extravagance in the Council, and when the fund was exhausted, the practicing physicians would again have to contribute to support the Council.

Dr. R. H. Preston exhibited a case of disease of the ankle joint. The trouble was of several months duration, pain was now very severe, swelling slight, tenderness not very marked, movements of foot were not difficult. All usual remedies, both internal and external, had been tried; he proposed to drill for pus, suspecting an interosseous abscess of the tibia. Drs. Grant, Horsey & McEwan concurred in his views.

Dr. Grant, jr., read a paper on "The Pathology

of Tubercle," exhibiting several slides of tuberculous and healthy tissue of various organs.

The Secretary read a paper from Dr. Malloch, of University College Hospital, London, reporting a case of "Hydatid Disease of the Liver," detailing operation and post mortem appearances.

The following officers were elected for the ensuing year: President, Dr. Cranston; 1st Vice-President, Dr. Preston, M.P.P.; 2nd Vice-President, Dr. Horsey; Treasurer, Dr. Hill; Secretary, Dr. Small.

The meeting then adjourned, to meet in Ottawa in January, 1885.

#### NOVA SCOTIA MEDICAL SOCIETY.

The annual meeting of the above named society was held in North Sydney, C.B., on the 9th and 10th of July, under the presidency of Dr. Somers, of Halifax. There was a good attendance of members. After routine, the President delivered an able and instructive address. The reports of the Standing Committees were then presented. The report on Medicine was prepared by Dr. Moore, of Kentville, and in the discussion that followed, the communicability of phthisis was chiefly taken up. It was decided to issue cards to the profession that a record may be had of all cases of this kind during the year.

The report on Surgery was presented by Dr. Stewart, in which he raised the question of antiseptic treatment of wounds, etc., upon which the President had also touched in his address. The report elicited considerable discussion.

In the afternoon, Dr. McGillvray presented the report on "Therapeutics," giving a succinct classification of recent popular remedies, showing that 97 in a list of nearly 300 had been more or less successfully adopted, while 190 had been rejected as useless. Dr. Angus, of Oxford, also reported for the same committee. The report on "Obstetrics" was presented by Dr. Page, in which he criticised the systems adopted by certain schools of practitioners.

The following gentlemen were elected members of the Provincial Medical Board under the new Medical Act: Drs. Somers, Wickwire, and J. F. Black, Halifax; Johnson, Sydney Mines; McIntosh, Antigonish; and Perrin, Yarmouth.

Dr. Tobin, of Halifax, read a paper on "The Modern Operation for Cataract Extraction," which was well received.

In the evening session a paper was read on "Medical Education in Nova Scotia" by Dr. Reid, Superintendent of the Insane Asylum.

On Thursday morning, Dr. J. W. McDonald read a paper on "Sanitation in regard to Diphtheria." In 1880 no less than 2,000 deaths occurred from this disease in Nova Scotia, but last year so great was the advance of the people in

sanitary knowledge, the death rate fell below 500. Dr. McDonald contended that the prevalence of diphtheria was entirely owing to the lack of sanitation. Quite an animated discussion followed in regard to the infectiousness of diphtheria. Dr. McKay followed with a paper on "Sanitary Legislation." He advocated the enforcement of our present sanitary laws, the establishment of a Department of Public Health in the Cabinet, and the appointment of an Inspector of Health for each County.

The following officers were elected for the ensuing year: President, Dr. H. B. McPherson; 1st Vice-President, Dr. John Stewart; 2nd Vice-President, Dr. T. R. Almon; and Secretary, Dr. J. W. McDonald. Dr. W. McK. McLeod was placed on the Standing Committee on Medicine; Dr. Lewis Johnston on that of Surgery, and Dr. Wm. McKay on that of Obstetrics.

In the afternoon the visiting gentlemen enjoyed an excursion on the harbor, as the guests of the C. B. Medical Association.

The society met again in the evening. The question of the union of the associations of the Maritime Provinces came up, but its consideration was deferred. Dr. Stewart gave notice of his intention to move next year in regard to the matter of physical education in the public schools.

After the usual votes of thanks, the society adjourned to meet next year in Halifax. Much of the success of the present meeting was due to Dr. McPherson, upon whom devolved the local arrangements.

#### MICHIGAN STATE BOARD OF HEALTH.

Reported for the CANADA LANCET.

The regular quarterly meeting of the Board was held in Lansing, July 8, 1884.

The Secretary presented a report on four outbreaks of cheese-poisoning in Michigan, during May and June. All persons who ate of the cheese were taken sick, (in all about one hundred and sixty-four persons), with the same symptoms, i. e., pain and burning sensation in the stomach, intense vomiting and purging, feeble pulse, cold extremities, and tendency to collapse. All finally recovered. Specimens of the cheese were analyzed. Everything about the factory appeared to be scrupulously clean, and nothing in vats, cans, or surroundings offered any explanation of the cause of the poisoning. Analysis showed no arsenic, copper, lead, iron, or other mineral poisons. When the cheese was cut or broken, a whitish liquid oozed into the pores, and in the liquid microscopic organisms were detected. For more than one hundred years the attention of the scientific world has been drawn to the subject of cheese poisoning by repeated outbreaks from time to time. It has been variously ascribed to diseased milk, decomposition

and the development of certain fatty acids, etc.; but it is not yet known what makes the cheese poisonous. The manufacturer said the cheese which produced the ill-results was all made between April 26 and May 26, 1884. It was made in the same manner and with the same care as other lots which had given no cause of complaint. Good cheese is only very slightly acid, and slowly reddens blue litmus paper. The poisonous cheese was intensely acid, instantly reddening blue litmus, when the paper was applied to the freshly cut surface. This test for poisonous cheese appears to be practicable. The blue litmus paper could be applied by any grocer to each freshly-cut cheese.

The Secretary reported an outbreak of small-pox in Ross Lake, introduced by a German immigrant. He said this outbreak was another illustration of how Michigan and the North-west suffer from the lack of a careful immigrant inspection service, such as was planned by the National Board of Health, and for a time carried on, but discontinued for want of an appropriation.

Owing to the spread of Asiatic cholera in Europe, and the liability of its introduction into this country at any time, it was decided to issue a circular to local Boards of Health on the prevention and restriction of cholera.

Other circulars on infectious diseases were ordered to be printed and distributed. A report of the work of the Secretary's office concluded the work of the Board.

#### Selected Articles.

##### CLINIC, BY ROBERTS BARTHOLOW, M. D.

**CHRONIC ILEO-COLITIS.**—The first case to be exhibited this morning, the child before you, was shown you some time ago, suffering with chronic ileo-colitis. The disease had been extremely persistent and severe, but under a properly regulated diet and the use of tincture of iodine and carbolic acid, the so-called carbolate of iodine—a half a drop of each being taken three times a day—there has been rapid improvement, and now the symptoms have disappeared, notwithstanding that the instructions in regard to the regulation of the diet have been imperfectly obeyed. You will remember that I insisted upon a change in the diet as of the first importance in the treatment of this case.

I hope that you will observe the character of the cough which the child has. It has frequently occurred ever since the existence of the ileo-colitis. Every time the child takes cold it has this hard, ringing cough which you now hear, and which is termed a "croupy cough." I have on several occasions insisted that this phrase is a misnomer. It is called croupy simply because it has the loud, ringing, metallic character which is as-

sociated with the cough of spasmodic croup. This is not the true croupy cough. The cough of exudative laryngitis is husky in addition to being ringing and metallic. The cough which this child presents is significant of laryngismus stridulus; that is, an affection of the larynx in which the muscles are thrown into a state of spasm. A child who during the day has been exposed to the cold, or who in the evening has eaten heartily of indigestible food, wakes up in the night with an attack of so-called croup. This is really an example of laryngismus stridulus, or spasm of the muscles of the larynx. In the case I have supposed there are two factors: the child takes cold, or it has an irritation of the gastro-intestinal mucous membrane. We can here apply with great certainty our physiological knowledge. The mechanism is very obvious. The pneumogastric nerve which supplies the mucous membrane of the fauces, and the gastro-intestinal mucous membrane in part, also has branches going to the larynx. This nerve is both motor and sensory in function. All the muscles of the larynx, with the exception of the crico-thyroid, are supplied by the inferior laryngeal nerve, while the superior laryngeal nerve is distributed to the mucous membrane and the crico-thyroid muscle. Now we have the terms of the problem. Irritation of the peripheral distribution of the pneumogastric nerve is referred to its motor branches, and the muscles of the larynx are thrown into a state of spasm. It would be a great mistake to confound this condition with true croup.

**LARYNGISMUS STRIDULUS.**—As laryngismus stridulus is merely a reflex spasm of the muscles of the larynx, those remedies which relieve spasm are the appropriate ones to use. In the present case we can prescribe a remedy which has a twofold effect; a remedy which benefits the intestinal inflammation, by acting through the nervous system, and which is also very effective in relieving the muscular spasm. This remedy, the bromide of potassium, will allay spasm of the muscles of the larynx, and it will also relieve certain kinds of irritation of the gastro-intestinal mucous membrane. In that disease commonly known as summer complaint bromide of potassium is one of our most efficient remedies. Why? Because it acts on the vascular supply of the mucous membrane, through the nervous apparatus, the semi-lunar ganglion and solar plexus. We have in this drug a remedy which fulfils all the indications of the present case. I direct five grains of bromide of potassium to be taken every three hours until the symptoms subside. The injunctions in regard to the diet must be repeated. When I last saw the child I carefully indicted the food which should be used. I now learn that the child has been given bread in considerable quantity, with the idea that bread, being the staff of life, can do no harm, and is always in place. In such cases as this bread is

always out of place. It is unsuitable; because it is an eminently fermentable substance, and in the process of fermentation acids are produced which have an irritating effect on the inflamed mucous membrane.

**CHLOROFORM IN TIC DOULEUREUX.**—Here is another case which you have seen before, and I can now show you the result of treatment. It is a case of tic dououreux, *i. e.*, neuralgia of the superior maxillary branch or division of the fifth nerve. You will remember that I pointed out the various features of this case, indicated the painful points, and referred to the remedies most appropriate in its treatment, and I prescribed a remedy which has been found singularly efficient. There is no fact in therapeutics more striking than the curative results of a few drops of chloroform injected in the neighborhood of this division of the nerve, when it is the seat of neuralgia. In my experience the superior maxillary division of the fifth nerve is, above all the divisions of the nerve, most apt to be affected with neuralgia. Fortunately, it is this division of the nerve which is most easily acted upon.

Given a case of tic dououreux involving this nerve, how shall it be relieved? Simply lift the corner of the lip and insert the needle at the junction of the mucous membrane of the lip and that of the cavity of the mouth, and pass it up until its extremity comes in the neighborhood of the nerve, and inject from five to fifteen drops of chloroform or ether. As a rule, chloroform is less painful and more efficient than ether. In this case the pain at once subsided, and in the majority of cases the result, if not permanent, lasts for a considerable length of time. I have a patient in Boston, who comes to me twice a year to have this injection practised. In his case the neuralgia is probably due to intra-cranial disease. This measure has accomplished that which nothing else has done. The relief which he obtains is complete, and lasts never less than six months.

**PARALYSIS FROM ENLARGED LYMPHATIC GLANDS.**—This case has also been before you, and I am the more desirous of presenting it to you as there were some rather confused points in regard to the diagnosis. In this patient the parotid gland and the lymphatic glands of the right side of the neck were greatly enlarged. This swelling of the glands was followed by an attack of hemiplegia. The mechanism which I maintained to be explanatory of this is the following: This mass of enlarged glands presses upon the cervical sympathetic and affects the intra-cranial blood supply. You will probably at once ask, "How is it that the paralysis involves the right side, for the enlarged glands are on the right side, and we know that the superior cervical ganglia controls the circulation of the same side of the brain?" We learn from the experiments of Bernard, which have frequently

been repeated, that when the cervical sympathetic is divided the corresponding side of the face and head becomes flushed, owing to the paralysis of the vessels. Suppose, however, that the nerve is merely irritated the unstriped muscles supplied by that nerve are thrown into a state of spasm, and this causes a diminution in the blood supply, the degree of which depends on the amount of spasm. In other words, irritation of the superior sympathetic produces anæmia of the brain. This does not explain the occurrence of the paralysis on the right side. It is a peculiarity of some cases that the impression is crossed. Why this should be has never been adequately explained. It is, however, a practical fact that the paralysis sometimes occurs on the same side as the lesion, and not on the opposite side.

The patient has been improving under the treatment, which consisted in the administration of one-half grain of sulphate of iron with  $\frac{1}{10}$  of a grain of sulphate of strychnia three times a day. As you can see he has great difficulty in combining muscular movements. Looking at the face you observe that on the right side, the labio-nasal fold which passes from the corner of the mouth to the corner of the nose, is much less distinct than it is on the left side. This is always an important point. A very positive evidence of paresis of the seventh nerve is often afforded by that sign.

**LUMBAGO.**—A short time ago I presented several cases of lumbago, and dwelt on the differential diagnosis and treatment. Some of the cases were strictly of a rheumatic nature, while others were more of a neuralgic character. I enlarged upon the essential differences between these two forms of the disease, and pointed out how certain states of the system had much to do with the results of treatment.

In this case we had to deal with a rheumatic lumbago, and we put him on the use of salicylic acid. The pain has disappeared and the patient is nearly or altogether well. In those cases which are distinctly rheumatic, there is no question as to the efficiency of this remedy. I at the same time advised the external use of oil of wintergreen, which has been found of service in muscular rheumatism so situated as to be reached by topical applications. The result here has been eminently satisfactory.

**INTERMITTENT FEVER.**—This little girl has had attacks which the mother supposed to be sick headache. They have occurred periodically, but of late have been increasing in frequency. On inquiry we learn that the attacks began with chilly sensations and often with a decided chill. This was followed by violent fever and headache, and terminated in sweating. With the commencement of chilly sensations there appeared nausea, violent vomiting and distress of the stomach.

Looking at the phenomena presented by this

history, there is no difficulty in making the diagnosis. The child lives in a malarial part of the city. The attacks begin with a chill, followed by high fever, and terminate in sweating. The frequent recurrences of the seizures, and their persistence, indicates the existence of changes in the condition of the spleen and liver. In many examples of chronic malarial toxæmia the spleen is enlarged, but sometimes it is smaller than normal; in other words, in the most chronic cases the spleen is the seat of a chronic splenitis. The liver is also changed, being affected with pigment deposits and disorders of its circulation—the nutmeg liver. The paroxysms will recur as long as these modifications in the condition of the liver and spleen are allowed to continue.

The question which we have to consider is, how best to arrest the attacks. As the gastric disturbance is so great, attention to the diet will be necessary. In order to prevent the occurrence of the paroxysm, quinine must be administered, in anticipation of the seizure. We must do something more than this. The condition of the liver and spleen must be taken into consideration, for although there is no enlargement of the area of dulness proper to these organs, I have no doubt that they are the seat of the changes which characterize chronic malarial toxæmia. The spleen in these cases is not necessarily enlarged, and may, indeed, as already stated, be smaller than normal. The organ may be in the condition known to practical pathologists as the "fleshy spleen." This is a chronic alteration in which the trabeculæ are very much increased in amount, and the splenic pulp proportionately diminished. There is hypertrophy and hyperplasia of the connective tissue elements, and hence its fleshy appearance.

There are two remedies to influence the liver and spleen, which are especially valuable. The one is aqueous extract of ergot and the other is an iodide, especially iodide of ammonium. There is also a condition of anæmia for which remedies of the chalybeate group are indicated. The most appropriate one in the present instance is the arseniate of iron. The best results will be accomplished by giving quinine, to prevent the recurrent attacks, and the use of a pill, containing the following:—

R.	Extracti ergotæ,	℥ j
	Ferri arseniatis,	gr. ss
	Ammonii iodidi,	℥ j. M.

Ft. pil. No. xx.

SIG.—Two pills three times a day.

This prescription should be very persistently used. Under this plan of treatment, we will see the paroxysms subside and the marked improvement take place in the general state.

**EXOPHTHALMIC GOITRE.**—Before us is a case of exophthalmic goitre. One of the symptoms is

very manifest. You see the marked protrusions of the eyeballs. Let me first give the quaternary of symptoms in which this curious malady consists : first, protrusion of the eyes ; second, enlargement and pulsation of the vessels of the neck ; third, enlargement of the thyroid gland, and fourth, rapid action of the heart. Two of the symptoms give the disease its name—the exophthalmos and the enlarged thyroid.

Are all the symptoms present in this case ? You see the condition of the eyes. I direct the patient to look downward ; the eyelid does not follow the movements of the ball, and a considerable amount of the sclerotic is exposed. The cause of the protrusion has been much disputed. It has been attributed to œdematous swelling of the tissues back of the eye, and also to the action of the unstriated muscle of the orbital membrane. The latter is probably the chief cause.

Looking at the thyroid, it is found that although it is not much enlarged, the change is characteristic. It is the right side of the gland which is involved ; the left side does not exhibit any enlargement. When only one side is affected, the rule is that it is the right side. The left side may subsequently be involved. In typical cases, the vessels of the thyroid also become enlarged, so that the gland pulsates like an aneurism and is often confounded with aneurism. The enlargement also presents the aneurisimal whirr and thrill. This enlargement may be either temporary or permanent. At first the enlargement is merely due to the vessels ; afterwards to the hyperplasia of the gland elements. In consequence of the lesion of the sympathetic, which is the seat of the trouble, the vessels dilate. The vessels of the neck in typical cases also become enlarged. We also find in this patient that the heart is affected. In typical cases where there is no lesion of the heart, the action of the heart is simply increased, the number of pulsations being increased, and the force of the pulsation much greater than normal. In old subjects, changes in the structure of the heart are apt to occur. In the present instance, when I apply a stethoscope over the heart, and especially over the mitral area, I hear a double murmur. This is not merely anæmic, but it is due to lesion of the valves. There are various changes which may take place in the heart, but no one of them can invariably be referred to this malady. As I have said, the heart is not necessarily the seat of any lesion in this disease, the only change being the increased number and the force of the pulsations. This might take place in one of two ways, either from irritation of the accelerator, or paralysis of the inhibitory apparatus. In this disease the lesion is in the accelerator nerves which arise from the sympathetic, and not in the pneumogastric nerve. Such is the mechanism and such the pathology of this affection.

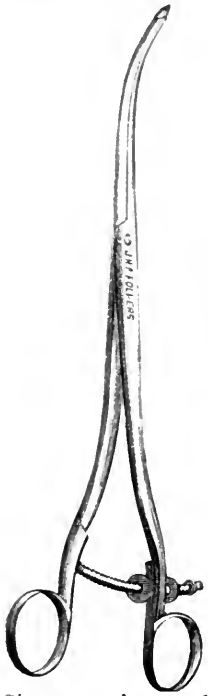
This being the nature of the case, what is the appropriate treatment ? I have effected cures in several cases by persistent galvanization of the cervical sympathetic. This is done by placing one electrode in the fossa behind the angle of the jaw, and the other in the epigastrium. The continuous current should be passed for five, ten, or fifteen minutes. This at once diminishes the pulsation, and the protrusion of the eye is lessened. Of course, one application will not affect a cure ; but I have no hesitation in asserting that in all uncomplicated cases, occurring in young subjects, a cure may be effected by the persistent use of the galvanic current.

In addition to this, remedies which modify the activity of the sympathetic system may be administered by the mouth. Digitalis has been much used, and has sometimes been of service. Ergot has also done good in many of these cases.

#### INSTRUMENT FOR OPENING PELVIC ABSCESSSES.

In the *Pacific Med. Journal*, Clinton Cushing, M.D., Professor of Gynecology Cooper Medical College, describes a new instrument for opening pelvic abscesses through the roof of the vagina. The most frequent site for a pelvic abscess is either in Douglass' pouch behind the uterus or in the connective tissue of one or both of the broad ligaments on either side of the uterus. It may also occur in the connective tissue between the uterus and bladder, but this is quite rare. It may open into the vagina, the rectum, through the abdominal wall, into the bladder, or into the peritoneum ; of the last mentioned, out of nineteen cases of pelvic abscess reported by Savage, of London, three terminated fatally in this way, and out of three cases opening into the rectum two proved fatal. The most favorable point for the escape of the pus is through the vagina. Between the uterus and bladder, there are no arteries of a size to make them of importance from a surgical point of view : but on either side the cervix, just above the junction of the vagina with the uterine neck, very important structures exist—no less important than the ureters and the uterine arteries. The uterine arteries which are as large as the radial, branch off the internal iliac on the sides of the pelvis and pass inward to the sides of the uterus just beneath the base of the broad ligaments and within a half inch of the roof of the vagina. The ureters pass over the brim of the pelvis beneath the pelvic peritoneum and run forward on either side the cervix to their position between the bladder and vagina. They cross the uterine artery about three-quarters of an inch laterally from the cervix, and both the ureter and artery are directly in the way if an at-

tempt is made to evacuate pus in broad ligament through the vaginal roof. The instrument—of which I herewith present a wood-cut one-third the size of the original—consists of two blades, which when closed form a trocar, and when introduced into an abscess direct, or along the side of an aspirator needle, the handles can be closed and the extremities separated so as to act as a dilator, and thus tear the connecting tissue sufficiently to furnish the most ample room for the escape of pus and the introduction of a drainage tube.



The manner of using it is simple. After making a digital examination and locating by the sense of touch the point in the vagina that you have determined to explore, turn the woman on her side in the Sims position, on a table before the window where the light is good. Introduce a Sims speculum and give it to an assistant to hold, and then seize the cervix with a small vulsellum to steady it. If the induration where the suspected pus is supposed to be presents no sense of fluctuation to the finger, pass a slender aspirator needle into the mass by means of a pair of strong dressing forceps and determine whether pus is present; if so, now make a slight incision alongside the needle and then introduce the trocar-pointed dilator by the side of the aspirator needle directly into the cavity of the abscess and close the handles before withdrawing it, leaving a large patulous opening into which the finger can be introduced, and of a character that does not tend to heal readily, admitting also of the easy introduction of a drainage tube. If fluctuation can be made out, the use of the aspirator is unnecessary. The advantage of this instrument over a knife is, that the danger of injuring the ureter or artery is reduced to a minimum; and the advantage over a trocar, is that of being able to make a large and free opening before withdrawing it, and with no additional risk. Doubtless the possession of this instrument with a knowledge of its use would give many men the courage to open and cure pelvic abscesses, that otherwise would allow them to go on to a bad ending. One of the difficulties attending the treatment of pelvic abscesses by openings through the vaginal roof is the inability to prevent the closure of the opening before the pus cavity has become entirely closed and healed, thus leading to a re-accumulation of matter. In order to meet this

indication, I have devised a self-retaining drainage tube that has proved most satisfactory in my hands. The tube is made by taking a piece of rubber tubing of pure gum, the size of a lead pencil, and cutting off a section three-quarters of an inch long, in which an opening is made at its centre, at one side, equal to the diameter of the piece of tubing. This is now fastened transversely across the end of the longer piece of tubing with silver wire. It is easily introduced by means of a pair of long-handled dressing forceps, and when in place will be retained without difficulty, unless considerable force is made to withdraw it. Through this tube the cavity of the abscess can be easily washed out if needed, and it can be left in as long as any purulent matter escapes.

### TAIT'S OVARIOTOMIES.

A correspondent in the *St. Louis Courier of Medicine* gives the following: The other day I asked Dr. Savage to what he attributed his and Mr. Tait's success—for they are very similar in their methods, and have much the same results—and he replied: "It can all be summed up in three words, 1st, cleanliness; 2nd, dryness, and 3rd, dexterity." To which I would add "carefulness."

The first, "cleanliness," brings up the question of antiseptics, which can be disposed of in a word, neither of them uses them. I may have something to say on this subject in a future letter, but, from what I have already seen, I must say that my confidence in Listerism has been very much shaken. Tait uses nothing but pure water, but Dr. Savage does use a little carbolic acid in the water in which his instruments are placed. The instruments and sponges are, of course, scrupulously cleaned; and plenty of water is used from beginning to end, but that is all the antiseptic that is used. There is no oiled silk or anything of the kind placed over the abdomen, but the parts are sponged thoroughly clean before operating.

There are only four persons who take part in the operation, the operator, his assistant, and two nurses to manage the sponges. The nurses have to redress before coming from the other patients, and in fact everything is done that can possibly be done to insure perfect cleanliness. If there are any visitors present, they are required to sign a certificate to the effect that they have not attended any post mortem examinations or contagious diseases for six days.

Before the peritoneum is opened, the external bleeding is arrested with Koeberle's scissor-shaped artery forceps, which are left on until it is necessary to complete the operation, when, as a general thing, all the bleeding is stopped. Just as soon as the peritoneum is opened, sponges are inserted



*ad libitum*. I have seen as many as twenty sponges in the abdominal cavity at one time. Before closing the incision, dry sponges are put in and taken out until they finally come out dry and clean, so that Baker Brown's old rule, "don't sponge the peritoneum," has been replaced with the opposite, "sponge until perfectly dry."

Mr. Tait is renowned for his short incisions. As a rule he seldom makes an incision longer than an inch and a half in simple ovariectomies, or the removal of the appendages. With this small opening, barely large enough to admit his two fingers, he diagnoses the case, and generally completes the operation. From what I have seen, and judging from a discussion that has just taken place in the *Lancet*, I am led to believe that no one ever attempts to perform the operation with as small an opening as Lawson Tait. He is remarkably skillful with his fingers, not only in abdominal section, but in every other operation I have seen him perform.

Carefulness in little things has much to do with success. In every operation there are the same number of artery forceps (12), the same number of sponges (either 12 or 20.) When the operation is about completed, and the sutures ready to be tied, the nurses have to count the sponges, etc. This, of course, is absolutely necessary, for it is a very easy matter to leave a sponge in. Several times I have seen the operator search the abdominal cavity for some time before a sponge could be found, that was known to be there only from counting them. The anæsthetic used is bichloride of methylene.

His method of treating the pedicle is the intraperitoneal, after ligating with silk. He uses a peculiar double knot for tying the pedicle, which, for want of a better name, I would call the Tait knot. The advantages of this knot are that while the whole is compressed into one surface, it ties the pedicle in two halves, and at the same time these halves are equally well compressed, so that very great constricting force can be employed. To tie with this knot a long handled needle is threaded with the silk required and pushed through the centre of the pedicle. The needle is then withdrawn, and a loop left on the opposite side of the pedicle. Then the loop is drawn over the tumor or ovary, and one of the free ends drawn through it, so that one end is above and the other under the retracted loop. Both ends being seized they are drawn through the pedicle, till complete constriction is made. A simple hitch is then made and tightened, as in an ordinary ligature. The pedicle is then cut about a third of an inch from the ligature.

The intraperitoneal method of disposing of the pedicle was a long while in being adopted, but it has been the means of lessening the mortality at least fifteen per cent. There are times, however,

when the clamp must still be used. But in all the operations I have seen, I have only seen the clamp used five times—four by Mr. Tait and once by Dr. Savage—the latter a Porro's operation, and the removal of a six month's child.

During the ten weeks I have been here, Mr. Tait has operated sixty-five times, with only one death. The fatal case was a cancer case, and the operation was a *dernier ressort*; the woman died in twelve hours. Thus, throwing out this case, which really ought to be thrown out, we have sixty-four consecutive cases in ten weeks without a death. When we think what was the rate of mortality only a few years ago, when we expected at least twenty out of every hundred to die, we may well rejoice at the results of the present methods.

### RETAINED PLACENTA.

Dr. T. Parvin in a paper read before the Philadelphia Co. Medical Society, thus discusses the management of retained placenta:—As long as the placenta is wholly attached, hemorrhage is impossible; the placenta is still a living structure and one with the uterus; to tear it loose, to directly detach it from the uterus, opens the way for perilous hemorrhage. Not only this, but such artificial detachment is usually incompetent, is liable to injure the uterine tissue, and the operator's hand may be the bearer of septic germs, or these may pass in with the air admitted during the manipulation, and find a congenial soil for their development in fragments of placenta, or blood-clots that are retained in the uterus. Therefore, unless hemorrhage demands immediate interference, the obstetrician refrains from passing his hand into the uterine cavity for the removal of attached placenta; a completely adherent placenta is not so dangerous as the intra-uterine use of the hand for its detachment. I believe, then, that armed expectation is wise in the latter case, only endeavoring, by suitable compression of the uterus with the hand acting through the abdominal wall, to determine or assist that retraction of the organ which is nature's method of separating the placenta. After the detachment of the placenta—a fact which is best learned by feeling a part of the organ with the finger passed into the mouth of the womb—we may, by friction and compression of the uterus, if needed, evoke uterine contractions which will cause its expulsion. Those who believe that the placenta presents its fetal surface at the os uteri, urge the value of moderate and continuous traction upon the cord, thus assisting the moulding of the mass to the orifice through which it is to come. This conservative view as to the management of so-called retained placenta has been strongly presented by Siredey in his recent work upon puerperal diseases. The common expression, retention

of the placenta, means very different conditions, each requiring its appropriate treatment.

Dr. Parvin concludes with a study of a ruptured uterus. The uterus was ruptured in consequence of a shoulder presentation, a case which ended in death the eighth day after delivery. Yet, he said, I would fail in duty to my profession that has been so generous to me, if I did not make the case fully known. The patient was a well-formed multipara; she had been in labor nearly twelve hours when I first saw her, the left shoulder presenting. Ether was immediately given until she was thoroughly under its anesthetic effect; and then, without violence, nay, with great ease, I passed two fingers behind the right knee, brought the foot down, and turning and delivery were effected in a few minutes; the placenta followed almost immediately; the child, quite a large one, was dead. The patient came out from the anesthesia satisfactorily; her pulse was good; there was no complaint, no shock, no great hemorrhage. Yet that woman had a ruptured womb, the tear beginning at the os uteri on the right side, involving the cervix and the lower part of the body of the uterus, this condition being made known by the post-mortem. If it be thought I ought to have known this accident at the time of delivery, I can only say that like ignorance happened to Dubois, to Hervieux, to Tarnier, and others—the first revelation of the uterine rent being made at the post-mortem; these silent tears of the womb are, as Hervieux has suggested, probably more frequent than generally thought. No, my self-reproach is not in this, but in not having made myself, or by another, an examination during pregnancy, so that the abnormal presentation could have been corrected, if not then at least in early labor. But let this pass. The great practical lesson to be drawn from the accident is not only the importance of an early rectification of a mal-presentation, but also an appreciation of the danger of rupture of the uterus, and how this accident occurs. The drawing now shown gives the position occupied by the child, and also and especially gives the change in form and thickness of the two cavities of the uterus, which, as so admirably described by Bandl, are formed when nature is unable to overcome the obstacle to labor found in such case. The one cavity is formed by the body of the uterus, and its walls become thicker and stronger; the other by the cervix, and its walls grow thinner—become indeed so attenuated and weak that a very slight additional strain at some point; that strain may come from a uterine contraction, or solely from the introduction of the finger; and thus peril from action, peril from delay must be before the obstetrician's mind when called to a case of neglected shoulder presentation.

Of course had I seen this patient an hour or two earlier, the event might have been different. The pressure of the presenting part had been so severe that a slough of the vesico-vaginal wall oc-

curred, and the patient, had she recovered, would have required an operation for the resulting urinary fistula. I have thought that possibly the uterine rent was in part the result of a slough also; but be this as it may, there was not the slightest indication given at the post-mortem that any hemorrhage in the abdominal cavity had taken place.

**THE EASY APPLICATION OF THE FORCEPS.**—One of the chief minor objections to the use of the forceps is the fuss and trouble necessary to place the patient, already much exhausted and worried, in the orthodox position close to the edge of the bed, and, when so placed, patients frequently complain of feeling unsafe, and as if in danger of falling.

Let the patient lie in the ordinary position on her side, and at a reasonable distance from the edge of the bed, then let the upper blade be introduced as a lower blade, and then passed posteriorly round the head of the child into its proper position as the upper blade. When this is accomplished, the lower blade may be introduced in the usual manner, and the two handles locked. No force must be used, but the handle of the forceps manipulated as gently as that of a catheter when being introduced into the male bladder. I have applied the forceps in this manner more than twenty times in the last three years without any difficulty, and without causing any injury to the head or face of the child.

In teaching the use of the forceps, I think too little is said as to the direction in which the force should be applied after the head has reached the perineum, and when it is considered wise or justifiable to terminate the labor with the help of the forceps. I believe the force should be applied anteriorly, in a curved direction, terminating in a line almost parallel with the abdomen of the patient; in fact, in the same direction in which one might imagine that the woman herself would pull if attempting self-delivery with the forceps. Were more attention paid to this point, I am convinced that many perinæa which are now lacerated would escape uninjured.—Dr. Cribb, *Brit. Med. Journal*.

**REMEDIES FOR GONORRHOEA.**—No 1. —R. Liq. ferri. subsulphatis, gtt.xv.; aquæ font q. s.,  $\bar{3}$  iv. No. 2.—R. Hydrastin muriatis,  $\bar{D}$  j; glycerinæ puræ f.  $\bar{3}$  ss; aquæ font q. s. f.  $\bar{3}$  iv. Directions. —Wash out urethra well with warm water, then inject formula No. 1. Six hours after use No. 2 by injection. Four days is all I ask for cure. This treatment has never failed where I have given it.—*Therap. Gaz.*

THE sulpho-carbolate of sodium, in thirty-grain doses given after meals, is recommended in flatulent dyspepsia. Also in ten-grain doses for nausea and vomiting, particularly in pregnancy.



# THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science  
Criticism and News.

Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.

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## THE SPREAD OF CHOLERA.

Considerable anxiety is felt by the public in regard to the probable appearance of cholera on this side the Atlantic. It is impossible to say how soon, or when it may reach our sea-coast, for in these days of rapid railway and steam communication the germs may be carried to very distant parts in an almost incredibly short space of time. But whatever opinions may be entertained regarding the spread of cholera, the duty of the civic authorities, boards of health and the general public is clear. It is not enough to spend a few hundred dollars in cleaning up the filth in back lanes and alleys, the most thorough inspection and disinfection must be enforced. If proper and timely precautions are taken there need be no dread of cholera. Its outbreak in Toulon was the result of gross carelessness, and its continued spread the result of the *most disgraceful unsanitary conditions*. Although the violence of the epidemic has considerably abated, the area is very much enlarged, it having spread into the interior of France and Italy. At last accounts an outbreak in Algiers was feared. Koch has given the following instructions regarding the methods of preventing the spread of cholera: 1. Avoid contact with cholera patients or clothes worn by them; 2. practise temperance in eating and drinking; 3. avoid food that comes from an infected locality—cook it well; 4. see that the drinking water is *pure*—boil it; 5. avoid large gatherings; 6. disinfect choleraic evac-

uations with carbolic acid; 7. vacate apartments of cholera patients six days; 8. wash the hands with soap and water and carbolic acid if they have been in contact with cholera patients or their clothing; 9. disinfect linen before sending to the laundry; 10. disinfect all clothing of patients before transportation. The best disinfectants for cholera are carbolic acid, corrosive sublimate, and the zinc and copper salts.

A singular circumstance is mentioned in connection with the cholera in Marseilles, viz., that the swallows migrated at the outbreak of the pestilence and have not yet returned.

There are no specifics in the treatment. As most cases are preceded by a painless diarrhoea, it is well to adopt early treatment, so as to check it in the outset. Hypodermic injections of morphine and the internal use of opium, aromatics and astringents will be found most serviceable. Stimulants should be used with great caution. Horner's mixture, which has been recommended by Hartshorne and Bartholow in the *rice water* stage, is as reliable as any of the numerous so-called specifics.

R—Chloroform,  
Tr. opii,  
Spts. camph.,  
Spts. am. aromat., aa ʒiss.  
Creasot., gt. iij.  
Ol. cinnamom., gt. viij.  
Spts. vin. gall., ʒij.—M.

Sig.—Dissolve a teaspoonful in a wineglassful of ice-water, and give two teaspoonfuls every *five* minutes. The following is the treatment adopted at Toulon and Marseilles:—In the first stage, twenty drops of laudanum are given with three grammes of ether, and ice in the mouth, to stop the vomiting. In the second stage, from ten to fifteen grammes of acetate of ammonia, the same quantity of alcohol, and injections of morphia, are given. If the breathing is embarrassed, oxygen is inhaled and the limbs rubbed with turpentine; and the *Medical Record* gravely adds, "the third stage is the coffin."

## SURGERY OF THE URINARY ORGANS.

Late English journals bring us a report of the first of a series of lectures to be delivered by Sir Henry Thompson on the surgery of the urinary organs. Perhaps no man, living or dead, was ever better qualified to speak on this branch of surgery.

With rare natural and acquired gifts he combines a varied experience, in his chosen specialty, extending over a third of a century. The skill and experience which have made his name famous in this branch of surgery, he now proposes to make an open book for the benefit of suffering humanity. Thus it ever is in the higher walks of medical and surgical knowledge. The light is not hidden under a bushel to serve a selfish purpose, but is rather so placed that all who look may see.

Sir Henry, in his preliminary remarks, stated, that he became a specialist not from deliberate choice but by the merest accident. When about entering on the practice of his profession the Council of the College of Surgeons offered for competition as the subject of a Jacksonian prize, the "Pathology and treatment of Stricture of the Urethra." To the accident of having obtained this award, and not long after another Jacksonian prize for an essay on the prostate, he attributes the shaping of a career which he had never marked out for himself.

The subject of the lecture before us is Stricture of the Urethra. Of all the diseases, coming within the range of surgery, to which the urinary organs are liable, stricture of the urethra is by far the most common. Its victims are numerous and are to be found in every locality. As the common method of treatment is only calculated to afford temporary relief, nothing but evil forebodings is in store for the unhappy sufferer. Year by year he grows worse, until worn out by suffering catheterization, bladder and kidney troubles, he at last succumbs. Most practitioners of any experience can recall several such cases. The smallest diminution in the urethral calibre in itself of no consequence or inconvenience, often sounds the death knell of our patient. A trouble so grave in its ultimate consequences should never be regarded as trivial and undeserving of the most careful attention. Incipient stricture too often goes by the name of "gravel," to be treated by diuretics, thus seeking to overcome obstruction by increased force which is absurd. Catheterization next follows, sometimes with a view to gradual dilatation, but more frequently for the purpose of affording temporary relief from retention. It is cheering to learn from such an eminent authority as Sir Henry Thompson that nearly all cases of stricture are more or less within the range of surgical control. We can do

no more than touch upon a few of the more practical points discussed in this important lecture.

For a simple stricture or narrowing, *the history of which is recent*, nothing need be done beyond gradually restoring the calibre of the canal to its normal state by means of flexible bougies, and for this purpose the style of bougie called "olivaire," is the one recommended, to be followed in severe cases by polished steel dilators. By the use of these or other dilators, according to the fancy of the surgeon, we are assured the normal calibre of the canal may be maintained in a large number of cases for a long period. When the passage has been restored it should be maintained so by an occasional regular use of the bougie by the patient himself. Congenital, organic, as well as acquired narrowings of the external meatus, and near to it, will not yield to dilatation. An incision is necessary in such cases. Strictures also within three or four inches of the orifice do not benefit much by dilatation. In after life when all the tissues become more rigid, dilatation is less effective. But it sometimes happens that this rigidity is absent even in the aged, and hence dilatation should first be tried. A decided tendency to contract, at any period, despite treatment by dilatation, calls for internal urethrotomy without delay. Prompt action will save much suffering, avert perineal abscesses, fistulæ, and organic changes in the bladder, ureters and kidneys. To delay until symptoms of such troubles appear involves complicity in a course which irretrievably damages the patient's life.

How to ascertain the extent and situation of the stricture, before attempting to divide the tissues which constitute it is the next point discussed. For this purpose nothing is better in the majority of cases than a bougie just large enough to pass through the stricture. In exceptional cases it may be desirable to use a series of solid bulbous-ended instruments, of which the stem is slender. Next follows a description of the urethrotome used by the lecturer. The mode of operation is then minutely described. The instrument should be constructed so as to cut from behind forwards.

The question is next asked and answered, what are the results of internal urethrotomy in relation to the reappearance of stricture? It is not possible to promise immunity from return. Great stress is laid on the necessity of *complete incision* of the con-

tracted tissues. The rule is that sooner or later the stricture will return. But in the meantime the patient has been placed in a condition of health and comfort for several years, saving him the suffering and organic changes which threatened his existence. When the trouble returns division can again be resorted to. It is not a dangerous proceeding, necessarily occasioning hesitation on the part of the patient when his condition requires it. As in the case of stone, stricture is to be dealt with as often as the case demands. In this way the implication of vital organs is avoided, and the patient is permitted to live out his days in comparative comfort.

The risks of the operation are small. Sir Henry has operated on about 340 patients. The number of operations must have exceeded the number of patients by several hundreds. Of the 340 on whom the operation was performed, six only died, or less than two per cent. Three of the deaths were due to pyæmia; one to embolism; two to extravasation and exhaustion, one of the latter being unfit for operation.

Such is a brief summary of the views of one every way qualified to speak; and such are the results of his long and wide experience. The low rate of mortality will be a pleasant surprise to many. Every surgeon cannot hope for results so satisfactory, yet we are convinced their publication will go far to disarm fear, and give such a stimulus to this branch of surgery as will diminish the suffering and brighten the hopes of many a doomed victim.

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#### BRITISH MEDICAL ASSOCIATION.

The fifty-second annual meeting of the British Medical Association was held in Belfast, beginning on the 29th of July, under the presidency of Dr. James Cuming. Additional interest was imparted to the proceedings by the presence of a number of distinguished foreigners both from Europe and America—Prof. Benedikt of Vienna, Zehender of Roostock, Cordes of Geneva, Drs. Pozzi and Du-jardin-Beaumez of Paris, Gayet of Lyons, Drummond of Rome, Grant Bey of Cairo, etc., from the continent; and Drs. Flint, Sayre, Jacobi, Billings, Moore, Jones and others from the United States. Drs. Geikie, Douglass, Graham and McFarlane were present from Canada. About six hundred members attended the meeting. The president's

address was on "The General Character of Epidemics," in which he referred to the present epidemic of cholera, and urged due vigilance on the part of the profession and the government. The subject of micro-organisms and their relation to disease was also considered. On the following day Dr. Sayre gave a demonstration of the application of the plaster jacket in curvature of the spine. The address on medicine was delivered by Dr. Ord of London, who took for his subject "Some Perversions of Nutrition caused by the Nervous System." He alluded especially to muscular atrophy dependent upon articular disease—Charcot's disease, rheumatic arthritis, gonorrhœal rheumatism, etc. The address on surgery was delivered in the surgical section by Sir William McCormac, in which he reviewed the advances made in "Abdominal Surgery" during the past five years, relating his own experience in two successful cases of gastrostomy for malignant disease of the œsophagus, sixteen cases of the radical cure for hernia performed as a sequel to herniotomy, and one of excision of a large goitre. His method of the radical cure of hernia was to excise the sac, and ligate the neck, suturing the ring. The address on obstetrics was delivered by Dr. George H. Kidd of Dublin, taking for his subject "Puerperal Fever." With regard to etiology, he claimed that it was due to either or both of two causes—traumatism or epidemic influences. The address on physiology, which was a most able and interesting one, was delivered by Prof. Redfern of Belfast, and was well received. He dwelt chiefly on the progress of physiological science and its influence in medicine and pathology.

The work of the sections was characterized with earnestness and energy. The social aspect of the meeting was as agreeable as it was varied. The citizens of Belfast spared no pains to make their visitors happy. Public and private entertainments took place every evening, and excursions were made on Saturday to the Giant's Causeway, Garron Tower, Newcastle and other places. Dr. W. T. Edwards was elected President for the ensuing year, and Cardiff, South Wales, chosen as the place of meeting in 1885.

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DR. KOCH has been decorated by the French Government with the *Legion of Honor*, in recognition of his services in the French cholera district.

## THE INTERNATIONAL MEDICAL CONGRESS.

The eighth session of the International Medical Congress was formally opened in Copenhagen on Sunday the 10th of August, by the president, Prof. Panum, of Copenhagen, in the presence of the King and Queen of Denmark, the Council of State, and the King and Queen of Greece. The attendance comprised about 1600 medical men of all nationalities, including about 100 English and 50 Americans. The *Medical Record*, of New York, with characteristic enterprise, gives a cable report of the proceedings, from which we glean the following. An address of welcome was delivered by the president, followed by a brilliant reply from Sir James Paget in behalf of Great Britain, Prof. Virchow in behalf of Germany, and Pasteur in behalf of France. A grand banquet was given in the evening. On Monday the work was inaugurated by the division of the Association into sections, sixteen in number. Prof. Pasteur delivered an address in the general session on "Micro-organisms and Vaccination," in which he referred to the report of the French commission, stating that of twenty-three protected dogs bitten by rabid animals in June last, all remained healthy, while of seventeen unprotected animals similarly bitten, fifteen went mad. He emphasized the practice of inoculating dogs only, and said if they were protected the disease would die out. Very interesting addresses were also delivered by the chairmen of sections and many excellent papers read and discussed. On the third day Prof. Tommasi Crudeli, of Rome, read an address before the general session on "The Nature of Malaria," and the means of making malarial countries healthier. Many interesting and valuable papers were also read before the different sections, too numerous to mention. The fourth day was devoted to excursions, one of which included a visit to Elsinore, the assumed scene of Shakespeare's tragedy of Hamlet.

It is expected that the next session of the Congress will be held in America, the invitation on behalf of the American Medical Association, through Dr. Billings, having been very cordially received. If so, our American confrères know well how to make it a success.

NEWSPAPER PARAGRAPHS.—Since our last issue we have received a number of newspaper paragraphs, containing reports of wonderful and rare "surgical operations" performed by medical men in different parts of the country. Some of these paragraphs are written in a style which makes only too apparent the source of their paternity. Others again are written in such a way that we may assume that they are the work of the "reporters." But it must be remembered that the code holds the medical men concerned responsible if their names constantly appear paraded in this way. In many of the towns and cities in this Province, and in other parts, medical men have been obliged to remonstrate against their names being used in connection with paragraphs such as above referred to.

*Apropos* of the above, the *Medical Times & Gazette* gives the following:—Members of the medical profession who have with reason made frequent complaints in our columns of the unprofessional advertisements appearing in the daily newspapers, will be glad to learn that, so far as the Royal College of Surgeons of England is concerned, an important step has just been taken calculated to check these practices by the removal, by resolution of the Council of that College, at a meeting on the 5th instant, of one of its Members, viz., Mr. George Washington Evans, who has, after careful enquiry and due deliberation, been judged by the Council to have been guilty of an offence against the by-laws of the College by the issue of advertisements and pamphlets declared to be "prejudicial to the interest," and "derogatory to the honour of the College," and "disgraceful to the profession of Surgery." The effect of this resolution will be that the name of George Washington Evans will also be erased from the Medical Register.

ONTARIO MEDICAL ASSOCIATION.—In accordance with a resolution passed at the last meeting the chairman of each temporary committee is expected to open a discussion next year on some subject to be named. The following are the subjects chosen:—*Surgery*—Chairman, Dr. Powell, Edgar—Subject: "Plaster Splints and Bandages." What fractures are best treated by them in private practice? What their advantages and what the dangers and limitations of their use? *Medicine*—Chairman, Dr. Tye, Chatham—Subject: "Diphtheria." *Ophthalmology*—Chairman, Dr. Ryerson,

Toronto—Subject: "On the use of Jequirity in affections of the eye." *Obstetrics*—Chairman, Dr. Temple, Toronto—Subject: "Intra-uterine medication."

CHILDREN'S TONIC.—The most pleasant and palatable disguise for quinine may be extemporized as follows:

R—Quinæ sulph.,	grs. xl.
Acid tannic,	grs. xx.
Tinct. opii camph.,	3 ss.
Tinct. cinchona,	3 ss.
Spts. lavender co.,	3 iij.
Syrup simp., ad.,	3 iv.—M.

Shake well before using. The dose will be usually one teaspoonful three times a day, but the amount of quinia desired to be administered should govern the size of the dose. It will make a beautiful creamy mixture, if the quinia and tannin are rubbed together on a pill tile or a sheet of paper with a spatula until all lumps disappear, then put in a suitable bottle and first add the paregoric, shaking at once, then the cinchona and lavender, followed by the syrup.

DAVOS-PLATZ AS A HEALTH RESORT.—The merits of Davos-Platz, Switzerland, as a health resort are becoming more and more appreciated by the highest medical authorities of Great Britain. The place possesses the great advantage of salubrity at all seasons of the year, so that patients may be sent there the moment it is discovered that their health requires the aid of its pure, bracing, dry and rarified air, and can remain without interruption until their recovery is complete. Good accommodation, suited to the habits and wishes of English visitors, may be had at the Hotel Belvedere, under the management of Mr. Cöester, who will gladly furnish any information that may be desired.

BRITISH DIPLOMAS.—The following gentlemen have successfully passed the examination of the Royal College of Surgeons, England, and were admitted members—Drs. H. W. Aikins (Toronto); C. E. Gooding, G. B. Rowell, and J. B. Loring (McGill). The following have taken the L.R.C.P., London:—Drs. G. L. Airth, W. M. Brown, and E. H. Williams (Trinity); E. E. Bronstorph and A. Stewart (McGill); and J. F. Bell (Toronto). The following have received the double qualification of

L.R.C.P. & S., Edin.:—Drs. S. A. McKeague, W. E. Sprague, J. Johnstoa, O. M. Belfry, R. Owens, A. S. Thompson, and E. T. Eade (Trinity); J. Hutchison and W. Porteus (McGill).

ANOTHER CHOLERA COMMISSION.—We have had the French commission and the German commission, and now at the eleventh hour we are to have an English commission. Prof. Klein and Dr. Gibbes are to proceed to India and study the nature of cholera, and to act in conjunction with a native commission recently appointed. The gentlemen named are well qualified for this important work and their investigations will be of service to the world, but we fear that the earlier German commission has robbed them of whatever distinction they might have obtained in their investigations.

TREPHINING IN EPILEPSY.—Dr. Briggs, of Nashville, read a paper at the recent meeting of the Am. Surgical Association (*Am. Pract.*, July), in which he claims the most brilliant results from trephining in epilepsy arising from traumatic causes. In his record of 30 cases, he gives 25 cured, 3 relieved, 1 not benefited, and 1 died. No antiseptic precautions were used. Such results clearly indicate the propriety of resorting to the operation.

A GOOD DIURETIC.—The following combination recommended by Dr. Fothergill, will be found a useful diuretic:

R	Pot citrat. ʒiiss.
	Spt. Juniper Co. ʒj.
	Tr. Digitalis ʒiiss.
	Inf. Buchu. ad. ʒviiij.—M.

Sig. One to two tablespoonfuls three or four times a day.

MEDICAL LIFE PEERS.—An amendment has been proposed to the British Medical Act Amendment Bill, to the effect that two physicians of over twenty years' standing be made life peers, and act as lord justices of appeal in medico-legal trials. Some such measure has been frequently urged by members of the profession in England, and if carried out will considerably strengthen the hands of justice.

The passing of the British Medical Bill has been again postponed till a more convenient season.

HONORS TO CANADIANS.—Dr. Osler, of Montreal, is an applicant for the chair of clinical medicine in the University of Pennsylvania, made vacant by the transfer of Dr. Pepper to the chair of medicine. Should he be appointed the loss to McGill College will be seriously felt. He has also been invited to deliver the Gulstonian lectures before the Royal College of Physicians, London, next spring.

APPOINTMENTS.—Dr. J. M. Cochrane, of the assistant staff of the Toronto General Hospital, has been appointed medical superintendent of the Hamilton City Hospital. We congratulate our young friend and also the Hospital upon this excellent appointment.

Dr. J. McDonald has been appointed to inspect all vessels arriving in the ports of the Miramichi District, N. B.

APPLICATION FOR DIPHTHERIA.—The following will be found a most useful formula :

R—Liq. ferri subsulph.,	3 iv.
Acid carbol.,	3 j.
Sodæ sulphit.,	3 iij.
Glycerini,	3 ij.
Aquæ, ad.,	3 iv.—M.

Sig.—Apply by means of a brush or swab every two or three hours.

PRURITUS VULVÆ.—Dr. William Goodell, of Philadelphia, prescribes for this disease : carbolic acid, one drachm ; morphine sulphate, ten grains ; boracic acid, two drachms ; vaseline, two ounces. Also, pat the parts with a sponge soaked in boiling-hot water. This is also a most excellent application for that rawness so often found between the thighs of the newly born.

HYDROPHOBIA INOCULATION SUSTAINED.—The commission appointed to consider the question of the prevention of hydrophobia by inoculation as advanced by Pasteur, has reported in favor of the correctness of the distinguished scientist's theory.

THE death of Prof. Jäger, of Vienna, the distinguished ophthalmic surgeon, is announced ; also Sir Erasmus Wilson, of London, the well known dermatologist.

## Books and Pamphlets.

THE AMERICAN SYSTEM OF PRACTICAL MEDICINE. Edited by William Pepper, M.D., LL.D., Philadelphia. In five volumes, with illustrations. Volume I., *now in press*. Philadelphia: H. C. Lea's Son & Co.

The publishers have just announced this magnificent work. For three years it has been in active preparation, and it is now in a sufficient state of forwardness to justify them in calling the attention of the profession to it as the work in which for the first time American medicine will be thoroughly represented by its worthiest teachers. A reference to the list of contributors will show the generous rivalry with which the most distinguished men from all the prominent centres of education, and from all the hospitals which afford special opportunities of study and practice—have united in bringing together this vast aggregate of specialized experience.

THE FIFTH ANNUAL REPORT OF THE ILLINOIS STATE BOARD OF HEALTH, for year ending 1883. Springfield, Ill. : H. W. Rokker.

The annual report of the Board contains besides the proceedings of the meetings, a mass of information on medical education and the regulation of the practice of medicine in the United States and Canada. It contains a digest of the medical laws and institutions in each of the several States of the Union, and also in Canada ; a list of Medical Colleges, Post-graduate Institutions, number of Physicians and Students, etc. It also contains articles on small-pox epidemics, vaccination, mortality statistics, and nomenclature of diseases, together with meteorological tables, all well indexed.

STUDENT'S MANUAL OF ELECTRO-THERAPEUTICS, by R. W. Amidon, A.M., M.D., Lecturer on Therapeutics at the Woman's Medical College, New York ; pp. 90. New York : G. P. Putnam's Sons.

This unpretentious little work aims at presenting, in the most concise language, that information necessary to the proper understanding of the construction and use of medical batteries. It also deals with the proper application of electricity in different pathological conditions, and the methods of electro-diagnosis.

*\*\*\* The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

# THE CANADA LANCET.

A MONTHLY JOURNAL OF

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CRITICISM AND NEWS.

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## Original Communications.

### AN ADDRESS ON ABDOMINAL SURGERY.

BY LAWSON TAIT, F.R.C.S.E., BIRMINGHAM, ENG.\*

Mr. President and Gentlemen,—Every gardener knows that a plant long grown on the same soil rises or sinks or somehow or other gets to a level from which it varies not so long as its conditions remain the same, and he knows as well that if he takes that plant to a new soil which suits it—if he grows it under new conditions—its growth, change, and development are practically endless. What we know of plants is, within limits, true of humanity; and if we require proof and illustration of this, where need we go but to this endless continent of yours.

I am not at present concerned with natural boundaries created by languages which come from Sweden and Poland, Denmark and Scotland, Russia and Ireland, which temporarily limit intercourse between different peoples who perhaps settled here. Still less do I trouble about a line on the map which marks a practical Republic on the south from a splendid Democracy on the north. I have only to do with the great fact of human history—I think the greatest fact—that from out of the troubles and distresses of our eastern countries, or out of countries oppressed by over-population, and still more by the effete policies of governments of past centuries dislocated into modern life, from these there has come a great country and a great people, whose growth, change, and development promise to be practically endless. Of my own country and my own people you will not expect me—you would not wish me—to say anything disparaging. We are an old and a respectable race, and, by virtue of your descent, you share that age, and you have brought over with you a

full measure of the respectability. But in transit you have lost that questionable virtue of extreme conservatism which we retain in every conceivable phase of life. We used to have mail coaches protected against robbers by armed men, properly called guards, and we continue to call our railway servants guards without the slightest reason save that they seem to be in some fashion successors to the blunderbuss-bearers of the eighteenth century. On the other hand, you very properly call the same officials conductors. We still build our railway carriages in compartments fitted to hold six people, confined boxes that are stuffy, inconvenient, wasteful of room, and dangerous, and we do this only because one hundred years ago we built our stage coaches on the same pattern, and we thought, and we continue to think, that by sticking three of these old coaches end to end we must of necessity construct the very best kind of vehicle for railway travelling. Untrammelled by tradition, you have continued to build carriages far more convenient and suitable in every way. You have even sent them over to England for our use some ten years ago, but they had actually to be removed from our railways because the public would not use them. I might gather further illustrations of this intensely conservative spirit which governs everything English. I might wander into the regions of politics and religion and hundreds of other sources, but I prefer to take one of which I can speak at length and in detail—one upon which I believe, if I read aright the compliment you pay me by asking me to appear here before you, I can speak with some authority.

In my youth the medical education of a British student was not considered complete unless he had made a tour of the schools of France and Germany, and, like others, I felt of myself as was said of Proteus:

“ 'Twould be a great impeachment to his age  
In having known no travel in his youth.”

But I wish now that the time and money therein spent had been directed to the western instead of to the eastern continent. And I now predict that ere long it will be to the medical schools of America that our students will travel, as did the apprentices of old before they settled down to the serious exercise of their craft. For many years past I have been visited by numbers of my professional brethren from this side the Atlantic, many of whom

\* Delivered before the Canada Medical Association, August 26th, 1884.



have settled down for days and weeks, and even months, to see my work. I have been overwhelmed by the kindest invitations to visit this continent, but till now I have never ventured across. This delay is an instance of British conservatism, for it is very little the fashion amongst us to take long holidays. I have not had a holiday for seven years, and only the most eminent doctors in England take an annual outing; but on this side I find that none of you think much of a trip across the water, involving leaving your businesses for three or four months, and, from what I have heard, the struggle for existence is as keen as it is with us, perhaps keener. My American visitors have, one and all, impressed me with the feature of mind which I fear in England we do not possess—the power of judging any question solely upon its merits, and entirely apart from any prejudice, tradition, or personal bias. No matter how we may struggle against it, tradition rules all we do; we cannot throw off its shackles, and I am bound to plead guilty to this weakness myself, perhaps as fully as any of my countrymen may be compelled to do. I may have broken free in some few places, but I know I am firmly bound in others; and my hope is, that my visit to a freer country and a better climate may extend my mental vision.

To come to my intended illustration, let me briefly remind you of the early history of abdominal surgery. The first operation for the removal of an ovarian tumor was performed unwittingly, in 1701, in a Scotch village; for Robert Houston began there a tapping, and finished by making a successful ovariectomy. It was not till 1809, eighty-six years after Houston's case was published, that his example was imitated, and even then it was not in Europe, but in the fresh soil of the backwoods of Kentucky that the young seedling obtained its first full growth, and from that time and from this country dates the history of abdominal surgery. But how slow the growth! In 1863 I heard my master, the Professor of Surgery in the University of Edinburgh, settle all this vast field of human progress in these few words: "Abdominal surgery is abominable surgery." Syme, the greatest surgeon by far with whom I have ever come in contact, shared the views of his colleague in this matter, and I fear that in both the sentiments originated far less in the merits of the question than in their mutual dislike (almost the only sen-

timent they had in common) of John Lizars, who, having read Macdonald's manuscript when it was sent to John Bell, was immensely struck by the success of the heroic Kentuckian, and was desirous of following his brilliant example. Most unfortunately for humanity, the success of Lizars was of a very doubtful kind, and abdominal surgery had to wait for the advent of Dr. Charles Clay and Mr. Isaac Baker Brown. The story of the latter brilliant and unfortunate surgeon is now a twice-told tale, and I can only repeat what I have said at length elsewhere—that his disastrous downfall was a misfortune for humanity, delaying as it did the progress of abdominal surgery for fully a quarter of a century. The whole question of this progress lay in the peculiarly narrow issue as to whether the pedicles of ovarian tumours should be dealt with inside the peritoneum or outside it. Here, again, the new country was first in the race; for between 1820 and 1830 the decision in favour of the intra-peritoneal treatment was given in America in such a way that the question ought never to have been reopened. The arbitrament of abdominal surgery between 1866 and 1876 was left in the hands of a man still living, and he carried through his practice a mortality so heavy as to be absolutely prohibitive of fresh enterprise. Mr. Baker Brown left off practice in 1866 with a mortality of ten per cent. with the cautery, whilst, after operating on a thousand cases, Mr. Spencer Wells had a mortality of twelve per cent. in the last hundred with the ligature, and over the whole thousand the mortality was exactly twenty-five per cent. With such results as these, the marvel is not that the conservative surgeons cried out twenty years ago that the craft was in danger, but that the removal of ovarian tumours ever became an accepted operation at all. As I have said over and over again, as I shall never tire of saying, to Keith is due the whole credit of the modern development of abdominal surgery, and it has ever seemed to me specially hard that while wealth and a title has been the lot of the man who had done nothing but obstruct progress, yet to the author of our present proud position, nothing has come save a good deal of misrepresentation and abuse. In 1878 the doctrines and practice of Lister, after twelve years of preaching on the part of Mr. Lister, had penetrated to London and were taken up by Mr. Wells and his assistants. I had practised all the details in



their ever-varying form, as recommended by Mr. Lister, from 1866 onwards, and gave them up one after another as I found they disappointed and hindered me. Finally I gave the spray and its adjuncts a long and complete trial—a trial far more careful in its details than anything I ever saw elsewhere, extending over three years. I have published in detail the disastrous results of this experiment, and at last gave up all these unnecessary dangers, and, since January 7th, 1881, my practice has been entirely free from all these details. Since then my example has been followed by Dr. Keith, Dr. Bantock, and by my colleague, Dr. Savage, and the only surgeon now who uses the Listerian details for abdominal surgery is Mr. Knowsley Thornton. He still claims for Listerism the most of our present progress, in spite of the fact that Keith, Bantock, Savage, and myself have all far better results without Listerism than Mr. Thornton has with it. Mr. Thornton went so far recently, as to say that his (Mr. Thornton's) bad results in hysterectomy were due to the fact that in this operation the Listerian details could not be effectually applied. But the facts of the practices of Mr. Thornton and Dr. Bantock, the two surgeons to the Samaritan Hospital, settle this question when they are contrasted. Mr. Thornton uses the Listerian details for hysterectomy as well as he can, and in twelve cases he has had five deaths, while Dr. Bantock does not use the Listerian details at all, and in twenty-two cases he has had only two deaths. The explanation of the difference will be evident to every one who has seen both of these gentlemen operate. To see Dr. Bantock do a hysterectomy is a lesson in surgery, and one from which I learnt a good deal.

To see my own work, I have been honoured with the visits of a large number of surgeons of this continent, some of whom I see here now. I believe they, one and all, came with a belief that they would find I had some secret antiseptic agent, the use of which was the explanation of my success. If I have such an agent, it must be of universal existence in nature, for I have made some of my visitors take the water from the tap and put it into the basins for the sponges, and over the instruments and into the abdomen. I have made them drink it, and have offered it to them for analysis, and, so far, I have not been detected in

any magic exercise. My visitors always ask to what I attribute my success, and I answer that I cannot tell. They frequently suggest that it is climate. My answer is that our climate is the most variable and uncertain—the worst in the world. It is not fresh air, for the great majority of my operations, and always the worst, are done right in the middle of a large manufacturing town.

If I may formulate my own answers, they would be briefly to this effect: I have given up my life to this work, and I engage in no other kind of practice; therefore I have a constant weekly experience of five or six of these operations, sometimes as many as eight or ten. I pay the most minute attention to every detail, and maintain an absolute rule of iron over my nurses and my patients. I will not, if I can avoid it, operate in a private house, for there I have no control over either nurse or patient, still less over foolish friends. I can best illustrate the extent to which I carry discipline by telling an incident which occurred recently of a kind of which I have had a few, but not many, experiences. For my private hospital I have a rule that when a patient is admitted she must go to bed immediately. A lady with an ovarian tumour arrived, after a journey of some hundreds of miles, and was asked by the nurse told off for her, to go to bed. She said she would not do so until she had seen me. The nurse assured her that I would not come near her till she was in bed. The patient remained obstinate and I sent a message to her that she must either go to bed or go home again, and she elected to do the latter, with much satisfaction to myself. She doubtless thought and you may think, the rule in question is an absurd one, but the absurdity is only on the surface. It is a test of the patient's obedience and confidence in me, and I know very well that with a patient who begins by disputing my orders and doubting the wisdom of my directions, I never could get on, and therefore it is better for both that we should have an early parting. My nurses I always train myself—in fact, I will not have one who has had previous experience, for I know very well that such a woman will inevitably, to save herself trouble, do something in a way she has done elsewhere, and probably for some purpose altogether foreign to my intention, and will therefore become to me a source of danger and annoyance. Finally, I give great personal attention to

cleanliness in every detail of my work. I trust no nurses or servants without overlooking, and am constantly and at unexpected times turning up carpets, taking down shelves, and rooting out cupboards. In this way, and by a process of weeding, I have obtained a large staff of good servants, and have formed a large establishment in which every available precaution is secured. I can give no other reasons than these for my success, and probably they will commend themselves to you.

There are some causes intrinsic to the work itself from which the success has sprung to a large extent, and of which a few words may here be said with advantage. The first, of course, is the discontinuance of the clamp, of which I have said a great deal elsewhere. Whatever Sir Spencer Wells may say to the contrary, neither with nor without Listerism would anybody go back to the clamp. But the curious thing is that, from our recent experiences in hysterectomy, it would appear that it is not so much the clamp that has been to blame as Mr. Spencer Wells' method of using it. Hysterectomy must always be a more serious operation than an ovariectomy. But Dr. Bantock has now obtained better results in removing the uterus with the clamp than Mr. Spencer Wells ever got in removing simple ovarian tumours, and we must bear in mind that Mr Wells always insisted that he used the clamp for his simplest cases with long and easy pedicles. Puzzling over this mysterious and startling contrast, I went to see Dr. Bantock operate, and amongst other things I found he had given up using perchloride of iron for the purpose of tanning the stump. I asked him why he had done so, and he told me he was quite sure that the use of the perchloride of iron had added greatly to the mortality of the clamp, because with a thick pedicle secured by a clamp it is impossible to accurately close the abdominal wound and prevent draining into the cavity. I did not at once accept Dr. Bantock's explanation, but I determined to use the perchloride no more. Like everybody else, I was prejudiced in favour of the statement made by Mr. Spencer Wells, that a putrefying stump would poison the wound; and therefore I could not make up my mind to allow it to remain without some kind of interference. Years ago, in blaming the clamp for our high mortality, I had pointed out the likelihood of this incomplete closure as being one of the causes, if not

the chief cause, of death; but I certainly did not suspect the perchloride of iron as being the fatal agent. A few days after my interview with Dr. Bantock I had to perform a hysterectomy, and I dressed the stump with crystals of thymol. The patient died of peritonitis on the fourth day, and that the thymol had trickled into her peritoneum we had proof enough. Since then I have done a hysterectomy without dressing the stump at all, and the patient has done perfectly well. It will be curious and no less instructive, if we find Dr. Bantock to be right, and that the use of perchloride of iron, the only contribution Sir Spencer Wells has ever made to abdominal surgery, should turn out to be the cause of his tremendous mortality. In any case, it is a remarkable example of how absurdly we are all governed by *a priori* statements absolutely void of any argument in support of them, and having been made by some one with an authoritative name and position, are accepted without doubt. If Dr. Bantock's brilliant results are obtained by others in the same way, then we have been going on destroying women with perchloride of iron merely because Mr. Spencer Wells said we should use it.

As the whole aspect of abdominal surgery is, at the present moment, controversial—as the progress and practice of this part of our art form the chief objects of my life, you need not be surprised if I have made this address somewhat of a polemic. The greatness of the opportunity—the fact that an address given to you will be read where mere utterances of mine would be passed by—obliged me to take advantage of the opportunity you have given me to carry on the discussion. The course of this particular line of work has, as you are all aware, taken a sudden bound of activity within the last few years, and the reason is a very simple one. The immense success of the removals of ovarian tumors such as threatened to destroy life with absolute certainty, which followed the efforts of Baker Brown and Keith, led some of us, myself especially, to venture into regions where life was not necessarily, or, at least, not apparently threatened, but where suffering was persistent and unendurable, and where the sufferers had been proved by protracted trial to be outside the powers of ordinary remedial measures. In a recent paper by Sir Spencer Wells, published in the *Med. Times and Gazette*, the argument is completely dislocat-

ed and put in an altogether *outré* fashion, and therefore I must here give a little attention to the views of that writer. He tells us that ovariectomy had, at one time, a mortality of 70 or 80 per cent., but I know not whence he gets his information. Doubtless it would be possible to find occasional examples of surgeons with a limited experience having such a heavy death-rate, but such isolated cases would not yield a fair statement of the facts. I read a few months ago in an American medical journal that in Italy there had been 100 cases operated upon with 53 deaths, and the newspaper recorded the fact that 34 surgeons were engaged in the sanguinary work. But when the work of men who can be called ovariectomists is examined, no such results are seen. Charles Clay was the first man who did ovariectomy in England, and his maximum of mortality in his first series of cases was 40 per cent., and it speedily fell to 25 per cent., and this is pretty much what has been recorded by Sir Spencer Wells of his own practice.

In the paper of which I am speaking, Sir Spencer goes on to say that "afterwards, when the strictest hygienic precautions were supplemented by antiseptics, and improvements in operative details were generally adopted, success became so great that ovariectomy not only took its stand as by far the most successful of any capital operation in surgery, but the risk attending it in a favorable case could truly be calculated as little, if at all greater, than that attending any case of natural child-birth, and, as a necessary consequence, early operations can be advised with less hesitation." The statements in this quotation are wrong from beginning to end. In the first place, the mortality of ovariectomy in the hands of Keith and myself still remains at or about three per cent., and we have shown the least mortality yet available. The mortality of natural labor, on the other hand, is certainly not .25 per cent. The statement that a diminished mortality has led to early operations ought to be exactly reversed, for it is the early removal of tumors and the discontinuance of tapping which have largely contributed to our present splendid results. Sir Spencer Wells' teaching inculcated the practice of tapping and its repetition until the patient was within measurable distance of the grave, but his successors have reversed all this with infinite advantage to their patients, and we now look upon tapping as a sort of surgical

crime. This material alteration in practice led us, step by step, in the direction I have indicated, and we began to discuss the greater advantage to which I have just alluded. Every specialist is familiar with the large class of miserable women who wander about from hospital to hospital, or from consulting-room to consulting-room, seeking relief from their ailments unavailingly.

Let me take the first class to which Sir Spencer Wells alludes in his recent paper on cases of uterine tumor. There can be no doubt but that there are hundreds of uterine tumors that give no trouble at all, but these are not the cases that come to us. If a woman has no pelvic trouble, she does not present herself to the gynecologist, and if she has a uterine tumor which gives rise to no symptoms, that tumor, of course, remains undiscovered. But when she suffers from distress occasioned by pressure on the viscera, from severe hæmorrhage, or increasing size, she comes to us and asks for advice. Suppose we find her suffering from a uterine myoma, what are we to do? The answer to this question is like the answer to every other of a similar kind. If the tumor is small, the woman comparatively near her climacteric, and the hæmorrhage such as can be moderated by rest in bed and the use of ergot, then she can be advised to let the tumor alone; but if the woman be not near her climacteric, and the hæmorrhage does not yield to treatment, especially after a fair trial of treatment, the tumor is found to be actually going on, then surgical treatment is demanded. Of course, each practitioner of medicine does, and always must, carry on his work in his own way, and there can be no doubt that within certain limits the measure of his success stamps the rightness or the wrongness of his methods. James Syme used to teach us that there were three methods of conducting our professional business, but that there was only one way to real success. He said there were three interests involved. The first in order is that of the patient; second, that of the professional colleague; and third, that of the practitioner himself. Syme insisted that the several interests should be rigidly kept in the order in which he placed them, or things would be sure to go wrong. I have never heard sounder advice. I have never lost sight of it, and so far as within me lay I have striven to follow it. In the proposal of a new proceeding two dangers clearly occur. The first is that of the

enthusiastic upholder of the novelty; he may be disposed to run too fast on the new line. The second is that of the obstructive who, merely a believer in the times that are past, can see no possibility of their improvement. For the first danger the remedy is a wholesome scepticism, leading into just and careful criticism; the remedy for the second is more difficult, for it involves the patient endurance of much misrepresentation, and a protracted combat upon the points of criticism which have no weight in themselves, and have an importance gained only by persistent reiteration. In the line of practice of which I am about to speak, the point most persistently urged against our new line of practice is that unnecessary operations are performed. Now, this is an argument which it is extremely difficult to argue upon, because those who speak on the two sides of the question start from altogether different standpoints. Those of a past generation, like Sir Spencer Wells, apparently regard it as justifiable to perform operations in this department of surgery only when life is pronouncedly in danger; we, on the contrary, of the younger school, believe we are justified in extending our practice for the relief of suffering, and we regard this as a higher function than that of the mere saving of life. To end the discussion on this point, I would point out that our critics endeavor to apply an arbitrary rule for the repression of abdominal surgery which has never yet been applied in any department of the art. Let me ask, if we find a man suffering slightly with the early symptoms of a small calculus, do we not at once proceed to relieve him by removing it from his bladder? In fact, in the domain of what is called general surgery, has it not become the established practice to perform operations which are accompanied by very considerable risk of life merely for the rectification of deformities, such as bowed-legs and knock-knees, which have not the remotest risk of life attached to them and which involve no kind of suffering. The ultimate court of appeal comes then to be the patient's own decision, and I do not find that persons prefer to go on suffering pain and the disabling effects of profuse loss of blood rather than submit to a surgical operation, the details and effects and ascertained risks of which are completely and candidly placed before them.

In the treatment of uterine myoma two alternatives occur, and these are both the subject of very

hot discussion on my own side of the Atlantic; they are the removal of the uterine appendages, and the removal of the uterine tumor itself by the so-called supra-vaginal hysterectomy. No one in Europe, at least only one so far as I know of any importance, doubts that removal of the uterine appendages arrests menstruation completely in the great majority of cases, arrests the growth of uterine myoma generally, and in many instances causes it to entirely disappear. Mr. Knowsley Thornton, Dr. Savage, Professor Hegar, myself and others, have reported numerous cases in detail. I have published a long series in the *Am. Jour. of Med. Science*, but Sir Spencer Wells dismisses us all in the brief sentence: "Vague, unsupported assertions have little influence upon the opinion of a thoughtful or a sceptical profession." Sir Spencer Wells must pass his retirement in some other occupation than in perusing the modern literature of his specialty, and therefore his criticism need hardly engage our attention.

The great majority of cases of uterine myoma, which come to us for surgical treatment, can be quite satisfactorily dealt with, and it is an operation having a small and steadily diminishing mortality. Since 1878 I have performed it many times with few deaths, but am unable to give the exact figures just now. The arguments used against it are, first, that of its mortality, but this mortality is the inevitable result of early work, and is therefore not a permanent objection. It was an objection urged twenty-five years ago against ovariectomy, but it no longer holds good against that operation. The second objection is that myoma itself is not a fatal disease, but this argument is not in harmony with my own experience. Even if it were a just one, however, it is admirably met by the plea entered at Ryde by Dr. —, of —, in the discussion of my paper on the subject, to the effect that it is to the rights and relief of the majority that we must have regard, and that the function of our profession does not end with the saving of life, but is chiefly that of relieving suffering.

Two other objections have been urged generally against the removal of the uterine appendages—that it sterilizes and destroys the patient's sexual appetite. Of course, a woman is completely sterilized by a uterine myoma ninety-nine times out of a hundred, so that the process of complete destruction of fertility is a matter of little moment. The other ob-

jection has been shown to be perfectly groundless, but even if it were not so, it could hardly be urged on the ground of morality that a woman should go on suffering because she ought not to suffer any diminution of that animal propensity which it is the chief object of the higher life of all religious culture to subject, and the subjection of which forms for all creatures the greatest difficulty in existence.

There are cases of myoma demanding surgical treatment upon which removal of the uterine appendages seems to exercise no satisfactory influence. Mr. Knowsley Thornton has made a very valuable suggestion—one which certainly deserves very careful consideration—that all cases of myoma requiring interference are first to be subjected to the removal of the uterine appendages, and then to subsequent operation if it should be necessary. The only objection to this I can offer at present is an incomplete one. I have pretty well satisfied myself that there is one form of myoma on which removal of the appendages exercises no control. The variety I have named the soft œdematous myoma. But it is not easy to recognize this form of tumor until after it has been removed. Again, there are a few cases, very few I have found them to be, in which the appendages cannot be removed, and we must proceed to hysterectomy. Finally, the removal of uterine tumors has had such brilliant results in Bantock's hands that I am in hopes that a new era for hysterectomy is being opened out.

Another class of cases wandering about after relief are those upon whom I have operated in large numbers, and have found chronic and incurable disease of the appendages in the form of chronic inflammation of the ovary, chronic inflammation and occlusion of the tubes, these latter being occluded and distended by serum, pus, or blood. When I first published my work on this subject there was, of course, a large amount of incredulity expressed about it, and this incredulity was not much lessened by the exhibition of a large number of specimens at various societies, and their permanent exhibition in the museums of the colleges of surgeons. Many, particularly amongst my metropolitan brethren, loudly asserted that there were no such diseases, and Mr. Spencer Wells stated at the International Medical Congress in London that if such cases did occur they must all go to

Birmingham. But Dr. Kingston Fowler has shown not only that they exist in London, but that they are far more fatal than I had any idea of, and that they have been and are overlooked and misunderstood in the metropolis just as they were overlooked and misunderstood in my own practice previous to 1878. Concerning this incredulity, please distinctly understand that I don't blame anyone for it. It is a necessary part of all human progress. I do not even blame my metropolitan brethren, as they seem to think I do, for not discovering these cases and properly treating them. That is the fault of the mechanical school of gynecology established by Simpson, and which still exercises a far too great influence over this department of our art. During the last twenty years displacements have had a great run, just as before that time everything was put down to ulceration, and no man considered himself properly armed for the treatment of disease unless he carried a speculum and a caustic stick about with him in his gig. The mechanical school revels in the sound and pessary, both useful enough instruments in their proper places, but, when misused, capable of endless mischief, for many of the so-called displacements are now known to be constituted by chronically inflamed and adherent tubes and ovaries which can be relieved by removal only.

You will ask me, at starting, to tell you how this disease may be recognized, and I have to answer that their diagnosis cannot now, and probably never will, be a matter of certainty. They begin generally in some acute attack of pelvic inflammation, from which the patient dates all her troubles; and when you get such a distinct history you ought at once to be on your guard. This illness may have arisen, for instance, in a closely-confined and confessed attack of gonorrhœa; or it may be an attack of pelvic perimetritis, occurring after a miscarriage or a labor; or it may have arisen in one of the exanthematic fevers or a simple cold. In some of the cases, however, you get no clear starting-point in the history, and then the diagnosis is generally more difficult. The symptoms are usually precise enough, yet unfortunately none of them are peculiar to the condition of which we are speaking. Pain is, of course, a leading feature; indeed, it is rarely without pain as a chief incentive that patients consult us at all. This pain is complained of as being constantly present, greatly aggravated by

walking, and becoming intense for some hours or days before the period, and lasting throughout its continuance. Menstruation is usually too frequent and too profuse. In the great majority of the cases the uterus is somewhat fixed, and a tender mass can be felt on one or other side of it, perhaps on both sides and behind it. When the tubes and ovaries are down behind the uterus and adherent there—and this is by far the most common condition—the diagnosis to a beginner is very difficult. Nothing looks more certain and easy than the diagnosis of subinvolution and retroflexion, and without further consideration a pessary is introduced, with no other result than that of aggravating the patient's sufferings; in fact, I may say that at this point her troubles will begin to be serious, and she will wander about to collect various kinds of instruments from various practitioners, until she ends either a helpless and hopeless invalid or dies from an attack of acute peritonitis. In some of my most marked and most successful cases there have been no physical signs whatever, and I have felt myself reluctantly justified in interfering only by manifest reality of the patient's sufferings.

Here let me just say a word about the much discussed question of subjective symptoms. Everybody has heard the celebrated story told of Liston—that a hysterical girl persuaded him to remove a healthy limb for supposed disease of the knee-joint. But is there any other story of the kind known? If there is, I have not come across it. We certainly do meet with women who will tell the most extraordinary and incredible stories about their sufferings; but the stories are so inconsequent and contradictory that there is no difficulty in discounting them. Besides, they have no support from the presence of corresponding physical signs. A woman whose story is real has a sequent narrative, and she will submit to treatment; while the woman who is a humbug flies off in a temper the moment the suggestion is made that she should submit to an operation in which she risks her life. I have never yet known a woman submit to an abdominal section in whom I did not find abundant justification for its performance, even in cases where I had been extremely doubtful about its real necessity before I undertook it. I have known many patients to whom I have made the proposal as a test of their reality, and who have, much to

my satisfaction, speedily taken themselves off to some other practitioner.

Of the details in these operations in these cases I have no time to speak. Indeed, I could deal with them satisfactorily only in a series of lectures. Suffice it to say that the operations are extremely difficult, for the structures are always very adherent, and the operator has nothing to guide him save the erudition of his touch. Concerning the cases of occluded and distended tubes, some of my critics have suggested, without any experience, that something short of abdominal section might suffice for their successful treatment, such as tapping the tubes from the vagina. But a trial of this proceeding long ago satisfied me of its impracticability and its uselessness, and my growing experience confirms me in the conclusion that we have no alternative. I am often asked concerning the subsequent history of these cases, and I am able to say I have published the details that the great majority of them are relieved at once and completely by the operation. There remains a tenderness of the stump in some of them for some months. In four very bad cases *fæcal fistulæ* formed, but in two the sinuses have healed and the patients are perfectly well. In the third case the fistula opens still at occasional intervals; and in the fourth case, by far the worst I have ever had, the patient being literally at death's door when the operation was performed, the fistula still remains, some twelve months after the operation, but even here her health has so greatly improved that I am hopeful of its permanent closure in time.

I have occupied your time already at too great length, and yet have left myself no time whatever to speak of a great variety of topics within the limits of the subject of my address of which I fain would have spoken—subjects entirely novel, and full of the deepest interest alike to the practical surgeon and to him who takes but an interest of a literary kind in the progress of our art. In fact, it is a matter of regret to me that I cannot address such an audience as this in a series of lectures rather than in an address which must necessarily be brief. It is one of the great defects of a position such as I hold—a defect inherent to a special line of practice—that it practically shuts out its follower from any chance of being a teacher. Besides this, I feel strongly as acting to my own

prejudice, and I am certain it is a misfortune that those who, like myself, are very largely engaged in work strictly limited to a department, can never communicate as successfully the results of their experience as can those who are engaged in teaching. I regret, therefore, that I must pass over without mention the important field of new work which has been opened up within the last few years in the surgical treatment of the liver, spleen, kidney, and intestines. I cannot even stop to speak of many other less striking, but no less important subjects, such as the treatment of pelvic abscesses by abdominal section and drainage, though all these are of less importance, in so far that they excite but little hostility; and what I have to say further to you I propose to limit to a brief discussion of a proposal made by Dr. Battey for the production, artificially, of the menopause for the purpose of indirectly benefiting patients from conditions more or less neurotic, the symptoms of which are apparently influenced by the recurrence of menstruation. It must be perfectly clear to the most casual observer that this is a field of an extremely ill-defined character—one which, at first sight, offers very intangible prospects of success, and in which the indications even of success must be very vague and indefinite. There can be no doubt that a large number of women suffer in such a way as to make it perfectly clear that if they were relieved from recurrent menstruation they would be improved materially, but there can be as little doubt that the application of this idea—in itself a brilliant one—requires the utmost care. I have no sympathy with stupid obstructionists who, because they scent danger in the air, would absolutely prohibit its application; but I have sufficient regard for the expression of every kind of professional opinion to recognize the necessity for the full exercise of caution. When the proposal was first made, I recognized this so fully that I selected for whatever experiments I should make in this direction a disease concerning the reality of which there could be no doubt whatever: I mean epilepsy. It is a perfectly easy thing to recognize by two facts alone any case of genuine epilepsy from mere hysterical imitation. It was, I think, Dr. John Hughes Bennett who clearly established the facts that none but the true epileptics ever seriously hurt themselves during the attacks, and that after the fits are over the epilep-

tic is always somnolent. It is certainly the case that in a large number of cases of epilepsy in women the incidence of the disease is concurrent with menstruation. It is also true that every epileptic woman, certainly whose case I have investigated, is worse during the menstrual week than at any other time. In some cases the epilepsy is absolutely limited to those days of the month during which the menstrual flow is in existence. It was, therefore, a perfectly easy thing to select a number of cases in which the experiment of Battey's operation seemed capable of justification. For the purpose of trying the experiment I selected six cases, and to these I have absolutely limited its application, though from the number of cases who have been sent to me for the specific purpose of having the operation performed, I suppose I might have been able by this time to have placed several series of attempts on record. The reason of my careful restriction has been that I did not care to prejudice the results of my other work by complicating it with what seemed to me a doubtful kind of proceeding, but all my care has been to some extent fruitless, for I have been persistently charged by a certain class of writers with having performed a large number of useless and unnecessary operations in removing normal ovaries from women suffering from nervous disorders. Indeed, so late as July 5th last, Sir Spencer Wells wrote the following sentences which, though they may have been intended for some one else, I cannot but suspect were levelled at me. They are as follows: "Just now something more than a word of caution against rash, dangerous and unnecessary operations is called for. We are startled by the reports of the removal of normal ovaries of young women suffering from nervous disorders, which may be exaggerated or imaginary; and it is to be feared that our professional honour is at stake, and that abdominal surgery in its latest developments is open to the denunciation hurled against the earlier ovariologists, and that with more reason than in 1850. Lawrence's question must be repeated, whether such operations can be encouraged and continued without danger to the character of the profession, and West's assertion that the fundamental principle of medical morality is outraged, cannot now be satisfactorily refuted."

Though I am fairly familiar with the literature of abdominal surgery during the last ten



years, I am absolutely ignorant of anything which can possibly justify such ridiculous exaggeration. I have publicly challenged Sir Spencer Wells to indicate the proceedings to which he alludes, and to produce the evidence upon which he bases his charges; but up to the moment of my leaving England he had not taken up the gauntlet. It is a somewhat remarkable fact that, in another journal of the same month, the same writer actually pleaded in favor of the removal of tubercular lungs, that such an operation would be justifiable if it saved one patient in twenty of those operated on, and it seems to me absolutely impossible to reconcile such a recommendation with the denunciation I have just read. So far as my own work in Battey's operation is concerned, in not a single one of the six patients operated upon were the uterine appendages normal. Two of them were carefully investigated by independent observers, one of whom was the well-known and accomplished pathologist, Mr. A. Doran, by whom the specimens were fully described and figured, in the *Brit. Med. Journal*.

The results of these operations were, in the first place, that all the patients made easy and uninterrupted recoveries; the operations were performed after the most careful consultation, and with the full cognizance on the part of the patients and their friends of the results which were certain, and the entire speculative nature of those it was hoped would be obtained. As I have already published the cases in detail, with the exception of the last, which was only performed a few weeks ago, I need not here repeat them, save in general terms, and that is to the effect that in two cases the results are such as to completely justify the proceeding. In both of these the disease before the operation was so intense that it was threatening life, but now it is almost entirely subdued, and the health of the patients has been enormously improved. In one case, the disease was arrested for a year and a half, and though it is now returning the patient has been transformed from a wretchedly feeble and broken-down girl into a healthy and robust woman, although affected by epilepsy almost as badly as before. In two others, the disease has been greatly modified, and the health of the patients has been immensely benefited. From this brief record it is quite a matter open for discussion as to whether the continuance of the proceeding can be recommended, and I am bound to say that I have not myself a very

strong opinion in the affirmative; but I think, if I had a daughter with feeble health, the result of pronounced menstrual epilepsy, I would advise her to have the operation performed. From what I have seen of it myself, I think there can hardly be any risk about it, and if performed with the precautions indicated, I do not think it can be brought under the sweeping category of Sir Spencer Wells as being either rash, dangerous or unnecessary. There is another argument, and I think one that may be said to have some moral force, in that it will assist in the prevention of the distinctly pronounced hereditary tendency of the disease, and we should at least hesitate before we entirely condemn it. Certainly a great deal more can be said for it than for the proposal of pneumonotomy for phthisis, on the assumption that the removal of a lung would only save one patient out of twenty. Removal of the uterine appendages for epilepsy would probably not kill more than one per cent., and I am certain it would materially relieve fifty per cent.; it would improve the health of the great majority of patients, and I don't think it would make any of them worse than they were before the operation. I am hopeful, therefore, that the verdict of professional opinion will not be adverse to a fair and reasonable trial of Dr. Battey's proposal, and I trust that the freedom from the prejudice and the shackles of tradition which we find on this side of the Atlantic will secure for it a fair field.

And now, in conclusion, let me thank you most sincerely, and not only you, but many other professional bodies and large numbers of professional friends, for the kindly, I may say overwhelming, reception I have met with at your hands. For many months before I left home, there arrived hardly a mail which did not bring me invitations to partake of public or private hospitality, and these kind expressions of regard brought forth feelings of deep regret that my stay here could not be prolonged for as many months as it is limited in days. There is one thing in this reception I recognize above all others, and it is, that you are treating me not on account of any merits of my own, but as the representative of a large body of men in my own land to whom you have owed much in the past, and with whom you are in the present united in a common bond of brotherhood and community of sacred purpose. I predict that in the future this union and unity will be more and



more complete. That it ever should be endangered would be a diaster for humanity. As the blunder of a century ago, which severed from the old country her most prosperous children, kept the whole progress of the world in abeyance for nearly two generations, so any future instance would be more diastrous still. God grant that we may never see it!

Dr. Grant, of Ottawa, in a few appropriate remarks moved a vote of thanks to Mr. Lawson Tait for his admirable address, which was seconded by Dr. Brodie, of Detroit.

Dr. McMillan, of Hull, Eng., doubted the advisability of removing the ovaries when no objective signs were present. He thought that Sir Spencer Wells' remarks on this subject were addressed more especially to young men, whose experience might be less than their enthusiasm, and not to men of large experience.

Dr. Trenholme, of Montreal, said he had performed the operation of removal of the ovaries twelve years ago, in a case where there was severe menorrhagia and metrorrhagia, with marked benefit to the patient. In recent years he had performed the operation frequently, and the results were, as a rule, satisfactory.

Dr. Hingston, of Montreal, congratulated Mr. Tait on his and Dr. Keith's disuse of Listerism in abdominal surgery, and thought the splendid results they had obtained were largely due to it. He thought with the speaker that the use of the perchloride of iron was a mistake. He took exception to the criticism on Sir Spencer Wells, and thought that public opinion, which had pronounced unmistakably in Wells' favour, was not a bad criterion. He disapproved of Mr. Tait's rule as a guide to the necessity of an operation, namely, that serious cases submit to operations and the hysterical do not. His own experience was that the hysterical carried out their acting to the end, at least in America, and gave an instance in illustration, where he had been implored to remove the appendages in a young person; he declined; the patient afterwards married, and all the symptoms had disappeared. He thought that when the objective signs were clear, no hesitation should be experienced in operating; but when the signs were altogether subjective, operations would be performed that were unwarrantable. An unnecessary operation of this nature was a crime against society, and it interfered with

the interests of the state. He did not agree with Mr. Tait that the operating surgeon could place the responsibility on the shoulders of the general practitioner who had advised the operation in the first instance. He gathered from the fact that only a few (6) out of a large number of cases of epilepsy had been selected for Battey's operation, that Mr. Tait did not favor it.

Dr. Brush, of Utica, N.Y., referred to Dr. Miner's operation of ovariectomy by enucleation, and said it had been his pleasure to watch the impetus which that valuable and unique suggestion gave to abdominal surgery.

He regretted that Mr. Tait did not refer to the removal of the uterine appendages in certain cases of insanity, to hasten the menopause. Prof. Wm. Goodell, of Philadelphia, has reported a few cases in the *Am. Jour. of Insanity*, in which he had successfully performed Battey's operation for the relief of insanity in patients in whom there was marked increased mental disturbance associated with the menstrual flow. With these cases in view, and bearing in mind Mr. Tait's statement that a mortality of not more than one per cent. need be feared, he would go home with increased faith in the propriety—nay, even the necessity—of the operation, in certain cases.

Dr. Heywood Smith, of London, said he agreed with Mr. Tait as to the greater difficulty in the operation for removal of the uterine appendages as compared with ovariectomy. As to the effect of the operation on fibroid tumours, his opinion was that it was of more use in cases of soft tumours than in those of a more dense structure. He had seen cases where, after the removal of both ovaries, profuse hæmorrhage continued so as to endanger the patient's life. But in cases of severe dysmenorrhœa, the result of chronic ovaritis and subsequent morbid changes in the ovary, he was convinced that the removal of the ovaries held out the best prospect of cure. He approved of Listerism, but occasionally used eucalyptus, which had this advantage over the carbolic spray, that there was no noise nor wet fog. In reckoning the advantages of the spray or the reverse, we must be careful to estimate the growing experience of each operator, and not hastily set aside Listerism under the idea that it is useless or worse, when increased success may most probably be due to the increased experience in operating. Under the use of anti-

septic measures at the (N. British) Lying-in-Hospital in London, the mortality during the past three years had been reduced to .062 per cent. He also said that the removal of the ovaries did not interfere with the sexual appetite, nor did it make women scraggy; on the contrary, many became plump after the operation.

Dr. Gardner, of Montreal, said he had been in the habit of removing submucous myomata which caused dysmenorrhœa, menorrhagia and metrorrhagia with Thomas' serrated spoon, and would like to ask Mr. Tait if he considered the removal of the appendages safer or more effectual in such cases.

Dr. Protheroe Smith, of London said he thought that the discontinuance of bleeding, by favoring congestion of the internal organs, had made ovarian disease much more common in recent years.

Dr. Fulton, of Toronto, asked Mr. Tait if there were not cases in which tapping as an aid in diagnosis was admissible? And if in some cases where there was extreme distension of the abdominal walls, it was not safer to withdraw a portion of the fluid to reduce the distressing symptoms?

Mr. Lawson Tait, in reply, said that as Sir Spencer Wells had never hesitated about knocking other people over the knuckles, he must not expect to escape similar treatment. Mr. Tait had only to say that any criticism he had ever made of Sir Spencer Wells was with most friendly intentions, dictated by an intimate acquaintance extending over many years.

Dr. McMillan and Dr. Hingston had both somewhat misunderstood what he had said about operations performed in the absence of physical signs. Those cases were absolutely limited to three cases of epilepsy and about three others in which the operation was urged, and the whole responsibility of its performance was accepted by the medical attendant in charge of the case. Such an instance was published by Dr. Ertuby in the *Lancet* about three years ago. Dr. Ertuby pressed me to perform the operation, and undertook its whole responsibility. As we found pyo-salpinx, the operation was entirely justified. The real protection alike of patient and surgeon is the introduction of the family physician, by whose concurrence the possibility of the performance of an unnecessary operation would be reduced to a minimum. It must, however, be remembered that surgeons who

practise this department of the profession are as fallible as other human beings, and that with them mistakes must as surely occur. They are to be judged, and their works also, by the same standards applied elsewhere, and not by others of an unjust and more exacting character.

In answer to Dr. Gardner, he would say that his own experience was wholly in favor of removal of the uterine appendages as a far safer operation than enucleation. Not only so, but as fresh tumors had grown after enucleation and removal of the appendages was ultimately required, he thought that the latter operation was in every way preferable.

He did not agree with Dr. Protheroe Smith regarding the lancet. There could be no doubt that ovarian disease was on the increase, but he could offer no explanation of the cause thereof. It certainly did not lie in the discontinuance of the practice of bleeding.

In reply to Dr. Fulton, Mr. Tait had to say that tapping never could help in a diagnosis as an exploratory incision could, and it was quite as risky. A small two-inch incision revealed in most cases the precise nature of the tumour, and allowed all fluid to be completely evacuated, if nothing more could be done. In some cases of great distension the removal of fluid before operating was advisable.

## CASE OF ANDROGYNÆ.

BY J. ALGERNON TEMPLE, M.D., M.R.C.S.

Prof. of Obstetrics and Diseases of Women and Children in Trinity Medical College, Toronto, etc.

A few days ago a peculiar case of malformation of the genitals in a female, came under my notice.

Mrs. D., aged 23, married 5 months, consulted me for amenorrhœa. The build of the patient was decidedly masculine, her voice deep, and a considerable quantity of soft dark hair on her upper lip and side of her face. She told me she had never menstruated, and that she experienced a considerable amount of sexual excitement during coitus. On making a vaginal examination, I found the canal not more than  $1\frac{1}{2}$  inches in depth, mons veneris covered with hair. The clitoris was about one inch long, with a complete prepuce, and the meatus urinarius opened about  $\frac{1}{4}$  inch below it. The mucous membrane lining the vaginal orifice was of a peculiar dark red, with com-

plete absence of the labia minora. On either side of the mons, two almond shaped bodies were to be felt, tender to the touch, easily moved about towards the external abdominal ring, with a round cord attached to their upper ends. These bodies, from their size and shape, resembled more the testicle than ovaries. Through this short vaginal canal I could not detect any uterine body, and on a careful examination per rectum, I satisfied myself that this body was absent. By bimanual examination I could meet my two hands. Firm pressure above the pubis, and the finger in the rectum proved to me that no uterus existed, and retaining one finger in the rectum, and a sound in the bladder, I could bring them together easily, proving the non-existence of the uterus. This patient has been for some five or six years taking medicines for the purpose of bringing on menstruation, without having undergone any examination to determine the cause of the absence of this function. Complete absence of the uterus is not a common malformation.

### THE EXCLUSION OF STRYCHNIA AND ARSENIC FROM ALL PREPARATIONS NOW IN COMMON USE.

BY GEO. PRINGLE, M.D., C.M., CORNWALL, ONT.

That strychnia is an invaluable remedy is unquestionable; that it is the cause of serious mischief in some cases, even where every precaution has been taken and every fact that could decide for or against its use been most carefully gleaned, is equally unquestionable. Having prescribed it during many years under most guarded rules for female patients, both married and unmarried, with good results, I have lately met with three or four cases the peculiarities of which I think well to bring before the profession, not so much for any practical lesson they teach as the moral they especially point, convinced that our failures, as we must have them, if properly noted, teach us more valuable lessons than our successes.

As the symptoms which indicated the employment of chalybeates with strychnia were much the same in all, I will not take up your space by describing more than one, but will give the result of the treatment in each.

CASE I. Mrs. J. K., æt. 30, mother of three children, consulted me in Jan. 25, 1883. She was of slight figure, complained of headache, vertigo, failure of sight, ringing noise in the ears, unpleasant taste in mouth and throat (especially in the morning), palpitation on the slightest exertion, poor appetite, bowels constipated, in short, functional derangement of every organ, but no disease, merely prostration. She was still nursing her fourth child, then fourteen months old; was perfectly sure she was not again pregnant; never had a return of menses since the conception of her first child, and never felt any of the unpleasant symptoms of pregnancy, but knew when she was so, as her children began to fail. The difference in the ages of the children ranged from twenty-two months to two years. Finding nothing pointing to pregnancy, I at once put her upon the following mixture:—

R—Tr. calomb.,	
Tr. rhei co.,	aa ʒj.
Acid nit.-mur. dil.,	ʒiv.
Liq. strych., B.P.,	ʒj.
Elix. iron et gent.,	ʒj.
Aqua ad.,	ʒiv.—M.

Sig.—One teaspoonful in water after each meal.

Ordered a podophyllin pill twice a week at bed time; also the immediate weaning of child, and to report the result of treatment in about two weeks.

CASE II. Was nursing her first child, then four months old, child large for its age; had no return of menses. I prescribed the following:—

R—Elix. iron, calisaya et strych.,	ʒiv.—M.
Sig.—One teaspoonful after each meal.	

Advised weaning the child, and rest as adjuvants; cautioned her as to the mixture and asked to know the result in about two weeks.

CASE III. Was the mother of three children; was nursing the third then four months old; her menses had not returned and did not usually do so until her children were ten months or a year old. There were no signs of pregnancy. I prescribed the same as for Case 2 and asked to hear result.

CASE IV. Was similar to Case 1, only I was more particular in my questioning if possible. The principle of treatment was the same as before, with a request to hear the result.

Now as to the result. In three cases out of the four the result was an abortion. Case 2 complained of most severe bearing-down pains, as in labor, and

painful micturition. Of her own motion she stopped the mixture for a time, the painful symptoms at once ceased, but upon again renewing her treatment they began to return, when she stopped it entirely. I then gave her a tonic, without strychnia, which benefited her at once. Case 1 had an abortion, but not for some time (about two weeks) after finishing her mixture. Case 3, whose infant was only four months old, had an abortion very soon after commencing her tonic. She stopped it while ill, began it after recovery, with no other ill results. Case 4, to her astonishment, also suffered an abortion, the first one in her life.

REMARKS.—Now admitting, for the sake of argument, that there are many causes, over which patients have no control, quite sufficient to produce abortion; admitting also that these three cases may have been merely accidental, they are very unpleasant, not to say dangerous, and as I do not care to run any more risk of such occurrences I have therefore ceased prescribing strychnia for any patient where conception has taken place.

The moral pointed is this: In nearly every tonic elixir, strychnia forms an ingredient, and amongst the laity many do their own prescribing where a tonic only is needed, although the principle is a bad one. When one reflects, therefore, that these elixirs are often prescribed in this way, many of them containing not only strychnia but arsenic, he cannot but ask himself the question, if so much mischief may be done quite unintentionally in such cases as mentioned, how much more may be done designedly?

I would suggest that, if it be possible, the profession should unite in urging upon manufacturers the propriety of excluding both strychnia and arsenic from all elixirs and leaving these two dangerous remedies solely in the hands of physicians.

## Reports of Societies.

### CANADA MEDICAL ASSOCIATION.

The seventeenth annual meeting of the Canada Medical Association was held in Montreal on the 25th, 26th and 27th August. There was a large attendance of members from all parts of the Dominion.

The President, Dr. Sullivan of Kingston, took the chair at 10.30 a.m., and Dr. Hingston, chairman of the Local Committee of Arrangements, welcomed

the members on behalf of the profession of the city of Montreal. Mr. Lawson Tait of Birmingham, Drs. McGraw and Brodie of Detroit, Dr. Murphy of Kansas, and Dr. McMillan of Hull, Eng., together with the past Presidents, were invited on the platform.

The minutes of the last meeting were read and approved. A large number of new members were proposed and elected.

Dr. Fulton read the report on Necrology, giving the names of members who had died during the year.

The Secretary read the report on public health by Dr. Canniff, and it was referred to the proper Committee.

The following officers of sections were nominated by the President, viz: *Medical Section*—Chairman, Dr. Thorburn, Toronto; Secretary, Dr. Burt, Paris. *Surgical Section*—Chairman, Dr. Roddick, Montreal; Secretary, Dr. Tye, Chatham. The meeting then adjourned.

The association again met at 2.30 p.m. The President read his address, of which the following is a brief abstract, after which the meeting resolved itself into sections:

After an introduction in which he referred to the manner in which the Association had been established immediately after confederation, and to the great good that resulted from these friendly meetings, he referred to the varying death rate in the Dominion as revealed by the last published volume of the census. In Ontario the death rate was 11.81 per 1,000, in British Columbia, 20.38, in Quebec, 19.07. Thus, Ontario, with a population 600,000 greater than Quebec, had actually 3,000 less deaths per annum, the figures being, Quebec, 25,930; Ontario, 22,727. This was due he found to the great mortality among children in this Province, the number of deaths from 1 to 11 years being more than sufficient to account for the difference. The figures show that in the Province of Quebec children between the above ages to the number of 16,142 die, a majority of 1,973 being boys, while in Ontario the number is 10,471, with a majority of 973 boys, the difference in favor of Ontario being 5,671.

Each child was valued at \$40 to the state by good authority, thus a heavy infantile death rate was an enormous loss, and it could be greatly reduced, as the diseases most fatal, such as small-pox, measles, scarlet fever, typhoid and typhus fevers, could be prevented or confined within narrow limits by proper precautions.

The importance of a bureau of vital statistics was also touched on. There were 3,567 physicians

in the Dominion, with about 800 students; while in the United States about 4,000 physicians were produced a year, and there were 90,000 doctors. He claimed that the average standard of the profession in Canada was equal to any in the world. The necessity of a high standard for students, so that uneducated men could be kept out of the profession, was pointed out. With regard to female medical education, Dr. Sullivan spoke in rather jocular, but at the same time friendly terms, declaring his belief that the presence of women in the profession would raise the standard, not lower it. With regard to the subject of medical service upon ocean steamers, if it was true that the British Act required that the surgeons be shipped only in Europe, then they should get the Act amended, as Canadians ought to have some of these appointments. Great need for reform was said to exist, and a bill was now before the American Congress requiring an extra physician on all ships carrying 600 people beside the crew. Nurses and hospitals were also demanded, and as the mortality was as high as 70.6 per 1,000, there appeared to be good grounds for such demands. Allusion was made to the researches now going on in regard to disease and to the germ theories, and particularly to the announcement that "the dread scourge cholera" was the result of a microbe, also to the inoculation for yellow fever, by Pasteur's method, which had been followed in Brazil with such good results that out of 450 foreigners inoculated with it, less than two per cent. died, while among the uninoculated the death rate was 30 or 40 per cent. He closed by referring to the fact that medicine was every year being held in higher estimation, and it was the duty of all medical men by deep study and research to keep up the standard of the profession. He also referred to the grand opportunity they would enjoy owing to the presence of the British Association in the city.

#### MEDICAL SECTION.

The first paper on the programme was "Puerperal Septicæmia," by Dr. Campbell, of Seaforth.

Dr. Sheard asked if Dr. Campbell had made any pathological investigations. He said cases occurred where the autopsy showed no lesions of the uterine tract.

Dr. A. Wright asked if the writer had discovered any other causes aside from laceration. He did not think it could be shown that the lacerations were the cause of the absorption.

Dr. Smith alluded to the identity of this disease with surgical fever, and advised disinfection of the hands and other antiseptic precautions.

Dr. Brodie (Detroit) thought in many cases he could predict before confinement that puerperal fever would follow. There was in some cases an erysipelatous element before birth.

Dr. Patterson thought puerperal fever and sep-

ticæmia were identical. It arises occasionally from atmospheric causes, without any other known source.

Dr. Mullin said that in the majority of cases he thought it due to decomposition of clots or shreds within the uterus. He did not think erysipelas was the potent cause it is sometimes represented to be.

Dr. McKay thought the poison might be generated in a debilitated system through imperfect resolution.

Dr. Campbell, in reply, thought the poison in his case originated entirely within—autogenetic.

The Chairman remarked upon the close alliance of erysipelas and puerperal fever.

Dr. Dupuis read a paper on "Nostrums and Medical Advertising."

Dr. Bray referred to the efforts that the Medical Council in Ontario had already put forth, and he hoped that the Councils in both Ontario and Quebec would be supported by the general profession.

Dr. Day said they were going to the Legislature to obtain power to strike from the register any member who should demean himself by unprofessional conduct.

In the Evening Session, Dr. R. MacDonnell exhibited two cases of "Lateral Sclerosis."

Dr. Osler remarked upon the probability of local focus being present in nearly all cases. He described cases of difficulty of diagnosis from caries of vertebræ.

Dr. Harrison of Selkirk read a paper on "Cerebro-Spinal Meningitis," describing several cases which had occurred in his neighborhood. He had alluded to a peculiar form of fever in a paper before this Association two years ago. He now considered that they properly belonged to the category of cerebro-spinal fever. The disease had occurred both in children and in adults.

Dr. R. P. Howard said the disease was rare in this country. In some few localities, as Sarnia, for instance, it is often seen. Its true pathology, and the explanation of these outbreaks would be interesting.

Dr. Bray had seen one epidemic of this fever in his district. The poor, and more particularly colored people were attacked. It was very fatal.

Dr. Geo. Ross took exception to arguments concerning the nature of the disease described, unless substantiated by *post-mortem* examinations. Tubercular disease of the nervous centres will often perfectly resemble the genuine cerebro-spinal fever.

In reply, Dr. Harrison said he treated his cases with bromide and iodide of potassium. The cases he had been describing occurred within a radius of six miles; the shortest lasted four weeks, the longest from 10 to 12 weeks. There was not always hyperæsthesia.

Dr. F. W. Campbell said the cases he saw in the epidemic 10 years ago were amongst the well-to-do.

Opisthotonos was generally present, then remittent and intermittent types of fever. Large doses of quinine did harm.

Dr. Osler said that the diagnosis of cerebro-spinal meningitis must be received with great caution. Of four cases submitted to him for *post mortem* examination only one showed a true inflammation of the meninges.

Dr. Mullin said that the cases observed in Hamilton occurred within four months. Isolated cases seen since were probably typhoid.

Dr. Lett, of Guelph, read a paper on "The Opium Habit and its Treatment," describing its ill results and the treatment which he found most beneficial.

Dr. Pickup enquired as to the value of coca leaves in the treatment. Dr. Lett replied that no substitute or antidote could be considered reliable.

Dr. H. Howard said that he never saw an opium-eater who had not been previously a drinker. He recommended gradual diminution of the dose of opium together with supporting treatment.

Dr. R. P. Howard next read a paper on "Some Varieties of Dyspnoea met with in Bright's Disease," referring especially to Cheyne-Stokes' respiration.

Dr. Geo. Ross described two cases bearing upon the case. The first was an elderly gentleman, suffering from spasmodic asthma. Examination of the urine showed the existence of Bright's disease. Subsequently there was typical Cheyne-Stokes' breathing, which continued during three or four months. The second case was a lady who had long suffered from asthma, but its dependence on Bright's disease was overlooked. A peculiar feature of her case was the sudden development, during these attacks, of pulmonary congestion, as shown by universal rales and bright blood in the sputa.

Dr. Osler referred to Cheyne-Stokes' breathing in a little girl one year old. He examined the urine, but found nothing. It passed off, and the child is now in its usual health.

Dr. Howard had never observed congestive symptoms. He also suggested that the child mentioned by Dr. Osler should be watched still, as the disease may develope. Frequent examination of the urine was absolutely necessary to make a real diagnosis. As regards treatment, he limited himself to treating the disease itself, as usual, with diaphoretics, vapor baths, etc. Sometimes nitroglycerine was useful.

Dr. W. Gardner, of Montreal, then read a paper on "Common Errors in Gynæcological Practice." He stated that the slighter forms of pelvic peritonitis and cellulitis were often not recognized. In regard to pessaries much misconception obtained. Some practitioners had unbounded faith in them, while others, of equally small experience, decried them as of little or no value. He thought that while pessaries and other therapeutic agents were

often of the greatest value in the treatment of displacements, such affections when chronic, were rarely completely cured. Constitutional treatment in addition to appropriate local treatment was often overlooked.

Dr. Trenholme did not agree in regard to the great frequency of chronic pelvic inflammations or their influence on uterine affections. He also approved of the use of pessaries in displacements.

Dr. Heywood Smith, of London, Eng., endorsed most of the author's view, but believed that perimetritic hæmatocele was the starting point of many cases of pelvic inflammation.

In reply to Dr. Brown, of Acton Vale, Que., Dr. Gardner said that he believed in the efficacy of hot water vaginal douches in the treatment of chronic pelvic inflammations.

Dr. H. Howard read a paper entitled "Materia Cogitans," giving his views on the relation between thought and brain-matter, after which the section adjourned.

#### SURGICAL SECTION.

The first paper was presented by Dr. Blackader, on "Case of Congenital Lipoma of the Foot." The enlargement which was noticed at birth, had increased in spite of continual elastic pressure by Martin's bandage. At the age of fourteen months the hypertrophied toes and tumor were removed by Dr. Roddick, and the wound healed kindly. Reference was made to the history of similar cases, their etiology and pathology, and to the views of Dr. Busey, of Washington, who referred the changes to congenital defect or disease of the lymphatic system.

Dr. Osler referred to a case in which there was congenital and progressive enlargement of the right upper extremity, the bones, muscles, etc., all being enlarged. In this case the palm of the hand was especially enlarged, owing to an increase in the amount of fat.

Dr. McGraw, of Detroit, mentioned a case which he had seen in Langenbeck's clinic in 1861, where there was enlargement of the left lower extremity and left side of pelvis. There was simple hypertrophy, uncomplicated with any tumor, involving all the tissues of the limb, which became so large that the girl was unable to walk.

Dr. Fulton, of Toronto, then read his paper on the "Thoraco-plastic Operation of Estlander." This paper will be published in a future number of the LANCET.

Dr. Hingston thought the question of operating in empyema a difficult one, for we seldom find two cases exactly alike. Estlander's operation would be more successful if portions of more ribs, but to a less extent, were excised. He recommended the thorough washing out of the chest with carbolic lotion and the free exposure of the whole surface as the best methods of treatment.

Dr. Kerr gave an account of a case which he had seen in consultation, which might be benefited by this operation. A free incision had been made, the patient sent to the sea-side and the general health attended to, and the discharge had diminished. He thought the curette might be used for the eradication of the pyogenic membrane.

Dr. Holmes thought that if cases of empyema were treated earlier, less disastrous results might ensue. Slow closure is often due to the fact that pus has remained in the cavity a long time, and by its presence interfered with the vitality or tone of the membrane.

Dr. Roddick alluded to the various methods of treating empyema in the Montreal General Hospital. In chronic cases the rule now is to excise an inch or more of one rib, if necessary, and drain by means of a tube of large calibre, antiseptic precautions being taken throughout.

Dr. Sherriff, of Huntingdon, then read a paper on "Hæmorrhoids," in which he had pursued with success the treatment of crushing, as advised by Pollock in Braithwaite for January, 1883, and as carried out by him in his wards at St. George's Hospital, London.

Drs. Sloane, Hingston, Tye and Roddick made remarks upon the paper.

In the evening session, Dr. Fenwick, of Montreal, read a paper on "Abscess of Abdominal Parietes extending from Meckel's Diverticulum," from which a large concretion escaped, composed of fæces incrustated with phosphate of lime.

Dr. R. P. Howard referred to a case he had recently seen, of acute inflammation and suppuration about the umbilical region; poultices were applied and in a few days a semi-solid concretion about the size of a bean escaped, and the patient said that five such had been passed. The patient recovered. Dr. Howard thought there was connection with the bowel, probably through the umbilical vesicle which had remained patulous.

Dr. King, of Hull, Eng., mentioned a species of abscess which began by a hard, deep swelling, situated so deeply that it was difficult to make out whether it was intra or extra-abdominal. They began in the muscles, sank towards the inguinal region and there appeared as carbuncular swellings.

Mr. Lawson Tait suggested that the calculus found by Dr. Fenwick should be cut, for he thought it was made up of cholesterin, and therefore hepatic in origin. He advised an immediate opening of the abdomen in all cases where the matter discharged from a sinus in the abdominal walls has a fæcal odor.

Dr. Shepherd, of Montreal, read a paper on "Ligature of Anterior Tibial Artery in a Case of Compound Fracture of the Leg," and showed the patient. Drs. Fenwick, Sullivan, Fulton, Giles, Girdwood, Holmes and Proudfoot took part in

the discussion, after which Dr. Gardiner, of London, Ont., read a paper on "Burns and their Results."

Dr. Stewart, of Montreal, then read an interesting paper on the "Action and Uses of Naphthalin." As an antiseptic it compares very favorably with iodoform. It is especially suitable in chronic ulcers and burns which have no tendency to heal. Iodoform is apt to induce a certain sponginess of a granulating surface, and after a certain stage in the treatment, does more harm than good. Naphthalin can be used throughout the treatment of a sore, and in place of retarding the healing after rendering the tissues antiseptic, it actually promotes it. It can be used either in a finely powdered form or in gauze.

Dr. Shepherd agreed with Dr. Stewart that iodoform was useless in granulating wounds; in such cases he used Balsam of Peru or naphthalin, but considered the balsam best as a stimulant.

Dr. Roddick used it in old burns and chronic ulcers with satisfaction, combined with boracic acid to facilitate the dusting of it. In empyema or large abscesses, he used naphthalized jute as an outside dressing.

Dr. Reeve, of Toronto, read a valuable paper on "Trephining the Mastoid" (fifty cases).

#### SECOND DAY.—GENERAL MEETING.

After the reading of the minutes, Dr. Mullin presented the report on Ethics, which was adopted.

The President then called upon Mr. Lawson Tait to deliver his address on "Abdominal Surgery," which will be found in this number.

#### MEDICAL SECTION.

Dr. Geo. Ross showed two specimens of Aneurism of the Thoracic Aorta, one obtained that day, the other two weeks previously. In one case, the physical sign of tracheal tugging had been present; in the other, absent. In both cases, this sign had been of great service in diagnosing the aneurism.

Dr. Worthington, of Clinton, read a paper on "Some cases of Diabetes Insipidus," one of which was complicated with exophthalmic goitre.

Dr. Harley, of London, made some remarks. He objected to the term Diabetes Insipidus, and preferred the term Polyuria. It may sometimes be connected with congestion of the kidneys, but is often present in chronic atrophy. In one of Dr. Worthington's cases twenty-five pints were passed in 24 hours. What is the exciting cause? Very often this cannot be traced. In saccharine diabetes, the sugar is the essence of the disease, and the quantity of water is only for the purpose of eliminating the sugar. The treatment of polyuria is very unsatisfactory. The only satisfactory management is the care of the patient's general hygiene.

Mr. Mills mentioned a case he had observed



under Dr. Stephen McKenzie. A lady had been in the habit of eating great quantities of sugar, which produced diabetes mellitus.

Dr. Sloane, of Blyth, instanced a case of polyuria where the amount of urine was very large and the specific gravity 1003. Iron was of no use. Bromide of potassium and ergot seemed to do good.

Dr. Sheard spoke of certain cases of diabetes mellitus, in which he had opportunities of examining the brain centres. Microscopical changes were found.

Dr. Geo. Ross said that Dr. G. Johnson, of London, had proved the existence of changed structure in the great semilunar ganglia of the sympathetic. He also referred to a case of polyuria in a woman, the subject of secondary cancer of the liver. He thought the co-existence of exophthalmic goitre of great interest in showing, in the same individual, disorder of another portion of the great sympathetic system.

Dr. T. Wesley Mills showed an improved method of making a quantitative test for sugar in the urine.

Dr. O. C. Brown, of Acton Vale, read a paper on "Impaction of the Pregnant Uterus in the Pelvis as a Cause of Abortion," giving cases which had occurred in his practice and which he had successfully treated.

Dr. Playter read a paper on "The Relation of the Medical Profession to the Public."

Dr. Gurd showed a patient in whom a cardiac murmur could be heard in the mouth and at a short distance from it, transmitted from the chest. The murmur was mitral systolic.

#### SURGICAL SECTION.

This section met at 3.30 p.m. Dr. Major, of Montreal, read a paper on "Buccal Breathing."

Dr. Elsberg, of New York, made a few remarks in support of the views held by Dr. Major.

Dr. Proudfoot, of Montreal, read a paper on "Paracentesis of the Membrani Tympani."

Dr. Reed, of Montreal, exhibited an interesting case of "Inguinal Hernia." The scrotum was of immense size. The hernia occurred twelve years ago, and is now irreducible.

Dr. Sutherland showed a case of "Keloid." The patches were situated on the chest, right gluteal region, and right shoulder.

Dr. Oldright, of Toronto, read a paper on "Myxo-Sarcoma," a sequel to the paper read last year.

Dr. Shepherd, of Montreal, read a paper on "An obscure case of Femoro-Popliteal Aneurism," in which amputation was performed, and showed the specimen.

Dr. Gardner, of Montreal, read a paper on "Uterine Myoma." He had operated successfully on four cases.

Dr. Strange, of Toronto, said that he never incised the cervix, but trusted to slow and gradual dilatation. He used free irrigation of the uterus after operating to wash away the debris.

Dr. Heywood Smith, of London, Eng., thought such method of operating was not applicable in all cases, especially in nulliparous women, in whom the parts are of necessity small. He thought that any incision made in the cervix should be allowed to heal before proceeding to operate.

Dr. Buller, of Montreal, read an interesting paper on "Jequirity in Granular Ophthalmia," and exhibited a rabbit on which he had been experimenting with this remedy. Dr. Reeve, of Toronto, gave his experience of its use.

Dr. Elsberg exhibited a new and improved forceps for removing foreign bodies from the throat.

Dr. Osler gave an abstract of his paper on "Pneumonia as a Contagious Disease."

The following officers were elected for the ensuing year:—*President*, Dr. Osler, Montreal; *General Secretary*, Dr. James Stewart, Montreal; *Treasurer*, Dr. Sheard, Toronto; *Vice-Presidents*, Ontario, Dr. Bray, Chatham; Quebec, Dr. Geo. Ross, Montreal; New Brunswick, Dr. Allison, St. John; Nova Scotia, Dr. Fraser, Windsor; Manitoba, Dr. Whiteford, Winnipeg; *Local Secretaries*, Ontario, Dr. Burt, Paris; Quebec, Dr. J. Bell, Montreal; New Brunswick, Dr. Walker, St. John; Nova Scotia, Dr. Almon, Jr., Halifax; Manitoba, Dr. Mewburn, Winnipeg.

*COMMITTEES*.—*Publication*, Drs. Kennedy, Montreal; Fulton, Toronto; W. H. B. Aikins, Toronto. *Medicine*.—Drs. Cameron, Toronto; F. W. Campbell, Montreal; Saunders, Kingston. *Surgery*.—Drs. Kerr, Winnipeg; Kains, St. Thomas; Waugh, London. *Obstetrics*.—Drs. Holmes, Chatham; McKay, Woodstock; Campbell, Seaforth. *Therapeutics*.—Drs. Oliver, Kingston; Sloane, Blyth; Tye, Chatham. *Necrology*.—Drs. Fulton, Toronto; Graham, Toronto; Cameron, Montreal. *Education*.—Drs. Pyne, Sheard and A. H. Wright, Toronto; Botsford and Allison, St. John; Arnott, London. *Public Health*.—Drs. Yeomans, Mount Forest; Grant, Ottawa; Harding, St. John; Robillard, Ottawa; Larocque, Montreal; Botsford, St. John; Playter, Ottawa; Drs. Bryce, Covernton and Oldright, Toronto; Hon. Dr. Parker, Halifax; Kittson, Winnipeg. *Arrangements*.—Drs. Ferguson, Kerr, Whiteford, Mewburn, Patterson, O'Donnell, Codd, Lynch, and Jones, with power to add to their number.

After formal votes of thanks to officers of the Association and others, the Association adjourned to meet in Winnipeg on or about the third Tuesday in August, 1885.

#### BRANT COUNTY MEDICAL ASSOCIATION.

The Annual Meeting of the Brant County Medical Association was held in Brantford, on Tuesday,



2nd September. The minutes of last meeting were read and confirmed. Dr. Winskell read an interesting paper on "Uræmic Convulsions," which was well received and discussed.

This being the Annual Meeting, the election of officers took place for the ensuing year, and resulted as follows, viz.: Dr. Marquis, Mount Pleasant, President; Dr. Winskell, Brantford, Vice-President; Dr. Fairchild, Mount Vernon, Secretary-Treasurer.

The term of office of Dr. McCargow, the representative of the Erie and Niagara division in the Ontario Medical Council having nearly expired, Dr. Henwood, the former representative, paid a just tribute to the zeal with which Dr. McCargow had performed his duties while a member of the Council.

It was then moved that Dr. Philip, of Brantford, be the nominee of the Brant Medical Association as the representative of the division in the Ontario Medical Council, which was carried unanimously. In accepting the nomination, Dr. Philip paid a high tribute to the ability of those who had represented the division in the Ontario Council since its inauguration. He dwelt upon several matters which would come before the Council, and said that whether he was elected or not, he should ever feel grateful to his medical brethren in the county of Brant for the confidence reposed in him.

Dr. A. J. Henwood was elected a member of the Association. Dr. Burt, of Paris, was appointed to read a paper at the next meeting, which will be held in Brantford in December. After some routine matters were disposed of, the Association adjourned.

## Selected Articles.

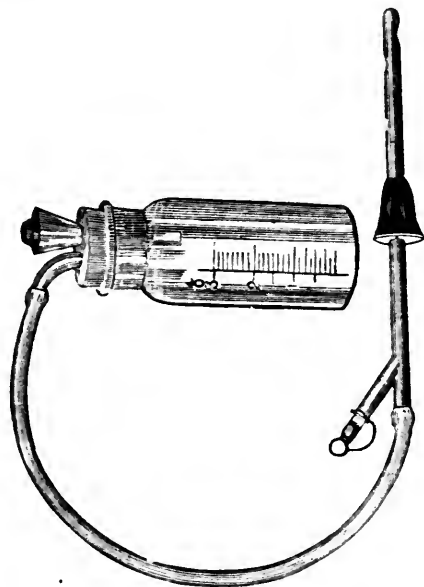
### APPARATUS FOR ETHERIZATION BY THE RECTUM.

Dr. J. S. Miller of Philadelphia read a paper before the County Medical Society (*Medical News*) in which he reported four cases of etherization by the rectum, and exhibited a form of apparatus shown in the cut. It consists simply of a water-bath, a graduated bottle provided with a funnel and valve for pouring in the ether, and a supply-pipe for conducting the vapor to the rectum. This tube terminates in a straight recurrent catheter, the exhaust channel of which is controlled by a valve. The catheter is furthermore provided with a movable collar for pressure against the anus—it having been found that the vapor tends to escape by the side of the tube.

Some question having arisen as to whether the vapor really does pass the ileo-cæcal valve, I deemed this a subject for legitimate vivisection, and, etherizing a cat per rectum, opened the ab-

dominal cavity, and noted that the small intestine was as greatly distended as the large.

In this method of etherization, the most obvious advantages are as follows:



1. Dyspnoea is avoided, and the patient is saved from the anxiety due to a sense of impending suffocation.

2. There is avoided the danger of simultaneous irritation of the superior laryngeal and pneumogastric nerves at the periphery—these irritations neutralizing each other in the respiratory centre, and suspending respiration entirely.

3. The danger of asphyxia is lessened—the patient not being drowned in his own mucus, and the integrity of the pulmonary mucous membrane as an organ of gas exchange is preserved. Of course, some vapor finds itself in the lungs, and acts there as a local irritant—elimination being by that channel. But the quantity is not great, and does not constitute a source of danger. In the cases reported, the increase in secretion was too trifling for discovery.

4. The stage of excitation is therefore not prolonged by the struggles for breath. In general, it may be said that the delirium of any alcoholic intoxication is a pleasant and good-natured one, unless the patient is crossed—as he certainly feels himself to be when a wet towel is pressed over his face.

5. Nourishment may be taken before operation to sustain the powers of life, and lessen the dangers from shock.

6. Return to consciousness is prompt—this stage not being prolonged by carbonic acid poisoning.

7. The anæsthetic seems as readily suspended as by the ordinary method—the bowel being promptly emptied by gentle massage.

8. Economy in ether is an advantage hardly to be mentioned with more important considerations.

The more obvious disadvantages are:

1. The exposure of person required—the abdomen being necessarily under observation, even if the catheter be inserted under cover.

2. More judgment and experience are required in the administration, than by the ordinary method—over-boiling in the apparatus, and too much distention, being both painful and highly dangerous. The warning to cease is sudden, and must be immediately obeyed.

3. Just as the other mode is inconvenient in oral surgery, so in perineal operations is the apparatus needed for this method, in the way.

4. In abdominal surgery, or if there be marked intestinal lesion, this mode is contra-indicated.

5. The inapplicability in cases of accident and emergency, when time cannot be allowed to prepare the bowel, has already been mentioned.

6. Diarrhœa has been noted in seven out of the thirty-seven cases on record, though in none of mine.

I believe this sequel is due to pre-existing intestinal lesion, to the lack of preparation, to a too great distention of the bowel, or to the accidental introduction of ether in liquid form. Furthermore, my method has differed from that of other experimenters in this respect, that instead of allowing the vapor to remain indefinitely, I secured a constant change by using a recurrent catheter, and introducing a certain quantity, or permitting it to escape, as indicated.

Other points of advantage and disadvantage may occur in later experience, and to other observers, and new dangers may be discovered. But I am convinced that this method is worthy of further trial, and will find its place in surgery, fulfilling its own, though not *all*, indications. Like all else in therapeutics, it must pass through the stages of bungling use, condemnation, and revival.

#### PYO-SALPINX AND HYDRO-SALPINX.

Dr. Wm. Goodell exhibited specimens of the above at the Obstetrical Society of Philadelphia, June 6th, 1884.

In the former case the lady was unmarried, and had suffered from pelvic pains and menorrhagia for several years. Last autumn a tumor was discovered by her physician, who deemed it a fibroid of the womb. Early this year her sufferings became so great that she took to her bed. Very large doses of morphia were needed, and septic symptoms now set in. After she had been in bed for several weeks, Dr. Goodell was called in to see her. The tenderness of the abdomen was so great that the examination was made under ether. Even then the diagnosis was obscure because she flinched and

her recti muscles became tense whenever the abdominal wall was pressed upon. A cyst was discovered, but of what nature it was impossible to determine. Dr. Goodell operated on her at his private hospital. The womb was studded with small fibroid nodules, posteriorly it had an outgrowth as large as a small egg. Closely adherent to the womb, to the pelvic fascia and to the intestines, was a thick-walled cyst of the left ovary, as large as the largest orange. The corresponding oviduct was very thick and enlarged to the size of a small sausage. It and the cyst were filled with a very dark purulent fluid, although there was no communication between them. The lower end of the cyst had become necrosed, and was so thinned out that it would very soon have given way at that point. On account of the presence of fibroids in the womb, the right ovary was also removed. Attached to the fimbriae of the oviduct were three very beautiful pedunculated vesicles; while two others not yet pedunculated lay in the stroma of the broad ligament. The recovery of the lady was uninterrupted.

In the case of hydro-salpinx, the patient was a widow aged 37, who had been sent to him in order to have her ovaries removed. Severe pains began a week before the menstrual flow, culminating during the flow and continuing one week longer, then fading gradually away. For three weeks out of every month she was confined more or less to the recumbent posture, and wholly so during the menstrual week. A tear of the cervix and one of the perinæum had been well repaired by two surgeons, but with no improvement. Dr. Goodell wished her at first to try the rest treatment with massage, electricity and graded muscular movements, for he had repeatedly cured cases of this kind through such a mode of treatment. She was, however, too poor to take this treatment privately, and was therefore urgent to have her ovaries removed. The operation was performed fifteen days ago, and she is now doing very well indeed. The ovaries as exhibited were much enlarged, and showed marked follicular degeneration. From this condition Dr. Goodell thought that nothing short of the operation would have cured her. Attached to one oviduct was a delicate vesicle with a thread-like stem of over an inch in length. In view of the frequency with which they are found, he could not but think that these vesicles played some role in the economy, and that they had sometimes a pathological bearing. He had on several occasions met with small post-uterine cysts which burst either spontaneously or under the pressure of an ordinary vaginal examination. Taking advantage of this fact, he had quite recently burst one designedly by bi-manual pressure. Such delicate cysts, and also those very movable ones which remained small without increase in bulk, he was disposed to attribute to these vesicles. After bursting

these cysts sometimes refill. One he had known to burst and refill at least six times before it disappeared. New small ovarian cysts had, in his experience, thick walls, and further, they rarely remain small any length of time. Dermoid cysts, on the other hand, often remain stationary for years, but they were generally not very movable, and they also had thick walls.

Dr. Robert H. Smith had found these cases of pyosalpinx very difficult of diagnosis. He had been present at an operation by Knowsley Thornton upon a case in which the lesion was double and both tubes and ovaries were removed. Rupture had occurred previously, and had been followed by peritonitis. The patient recovered.

Dr. B. F. Baer inquired if Dr. Goodell would recommend rupture of cysts arising from the carotids of morgagni.

Dr. Goodell would consider it good service for the purpose of preventing the further growth of the cyst. He had always found the fluid in such cases to be unirritating.

Dr. Albert H. Smith remarked that Schroeder holds that the fluid of an ovarian cyst is not noxious to the peritoneum. He makes no effort to secure the peritoneal cavity from its ingress during the operation, and yet his statistics show at least fair success.

In response to a question by Dr. C. Meigs Wilson, Dr. Goodell stated that the dressing of the wound after the operation was glycerole of carbolic acid with the Lister gauze.

Dr. Goodell also gave the following history of a case of hysterectomy. The woman was unmarried, aged 47. Her monthly fluxes began to be free in 1867. A year ago they became so exhausting that she could not pursue her trade as a seamstress. On April 30 she consulted Dr. Goodell, who found the whole abdomen filled with multiple fibroids of the womb. The cervix had disappeared and the os uteri lay so high up that it was not possible to introduce the sound. The operation was performed at the Hospital of the University of Pennsylvania, on May 22, on the same day with the preceding case. One outgrowth as large as the two fists contained a cavity filled with cheesy matter, and was so adherent to the abdominal wall and intestines as to need the knife for its release. It was possibly the right ovary, but he was by no means certain. Koeberle's wire-clamp was passed around what corresponded to the neck of the womb, but it was as large as his arm above the elbow. The woman's recovery thus far has been uninterrupted. The temperature reached 100° but once. The clamp fell off on the 16th day, leaving a very deep funnel-shaped pit. He had intended to exhibit the specimen, but it was too bulky to carry and also had become quite offensive. In this case had he been able to reach the ovaries or to have discovered them he would have removed them in prefer-

ence to performing hysterectomy; but the firm adhesions prevented the rotation or the lifting up of the tumor, hence the ovaries were inaccessible. Sometimes even when the uterine fibroid can be lifted out of the wound and the ovaries reached, these organs are so embedded in the fibroid, or so drawn out in ribbon-form on the surface of the tumor as to make their complete removal impossible. When, however, the ovaries can be removed with safety, the operation is a most promising one, as he could attest from several most successful cases.

DIAGNOSTIC SYMPTOMS IN THE DISEASES OF CHILDREN.—Politzer gives the following concerning the value of certain symptoms in children's diseases (*Deutsche Med. Zeitung*, May 19, 1884): 1. The symptom of a strongly-marked nasal tone in crying points to the probable existence of a retro-pharyngeal abscess. 2. A loud and very long-continued expiratory sound, with normal inspiration and the absence of dyspnea, is significant of chorea major. Sometimes this sound resembles the bellowing of an animal, and may continue for a long time as the only symptom of chorea. 3. A thoracic, sighing inspiration indicates cardiac weakness. This is one of the first symptoms, appearing before cyanosis or pallor of the face, thready pulse, coldness of the extremities, or the other well-recognized signs of weak heart. 4. A marked diaphragmatic expiration, accompanied with a fine, high-pitched whistling, points to bronchial asthma. 5. A marked interval between the end of expiration, and the beginning of inspiration renders the diagnosis of catarrhal laryngitis without exudation probable. 6. There is no special significance in the loud, sort of bleating expiratory sound sometimes observed in infants during the first months of life. It seems to depend upon a modified innervation within physiological limits, and resembles the want of rhythm in the cardiac movements occasionally met with in the early years of childhood.

The following symptoms are indications of cerebral diseases: 1. A peculiar drowsiness, continuing for several days, unaccompanied by fever or other disturbance, is indicative of basilar meningitis. This is a more valuable sign than headache, vomiting, or a slow, irregular pulse, since the latter may occur in various extracranial diseases. 2. A tense, elevated anterior fontanelle points to intracranial effusion. If it be very prominent, resistant to pressure, and without a sign of pulsation, there is almost certainly an intermeningeal hemorrhage. A deeply-sunken fontanelle indicates inanition and a diminished volume of blood. 3. Very slow movements of the eyes, followed by fixity in one position, a vacant stare, and a peculiar lazy closing of the lids are signs of a beginning basilar meningitis. The character of the cry is of value sometimes in the diagnosis. 1. A fit of shrill crying, lasting for

two or three minutes, accompanied by an expression of fear in the face, and coming on regularly an hour or an hour and a half after the child has gone to sleep, is the expression of night-terrors. Quinine, given in a rather large dose one or two hours before bed-time, is an effectual remedy against this trouble. 2. Periodical crying-spells, of five or ten minutes' duration, coming on sometimes during the day but more frequently only at night, point to cramps in the bladder, provided that we can exclude intestinal or gastric colic. This is speedily cured by emulsion of lycopodium with or without belladonna. 3. Crying while at stool and an evident dread of the act of defecation are signs pointing to fissure of the anus. 4. Hard, continuous crying, expressive of severe pain, together with frequent putting of the hands to the head or rolling of the head in the pillow, are evidences of otitis media or pain in the ear from some other cause. 5. When for days and weeks the child cries on being moved, and when there is also profuse sweating and an elevated temperature, the disease is rickets. 6. Frequent crying, with habitual sleeplessness during the first two years of life, are found in anæmic and poorly-nourished children, or in those with congenital syphilis. He also recounts some other single symptoms which aid in diagnosis. 1. The peculiar physiognomy of children suffering from congenital syphilis. The sinking in of the root of the nose, the sallown complexion, the scanty eyelashes, the yellowish edges of the eyelids, and the rhagades on the underlip are characteristic of hereditary syphilis. 2. A falling together of the *alæ nasi*, and an absence of all motion in them during inspiration, point to hypertrophy of the tonsils. 3. A weakness and loss of motion out of all proportion to the gravity or duration of the accompanying illness should raise a suspicion of infantile paralysis. 4. A partial loss of hearing after a sickness is often due to a circumscribed meningitis at the base of the fourth ventricle. 5. Depression of the mental faculties occurring after a severe infectious disease is frequently indicative of a beginning acquired idiocy. Strychnine exerts a favorable influence in these cases. 6. Retarded ossification of the skull may imply rachitis. 7. A stiff carriage of children in walking, standing, sitting down, or stooping, is observed in commencing Pott's disease. In children who do not walk there is a painful contraction of the features when they are lifted up or set down. 8. Constant vomiting of all ingesta, lasting for several weeks, in children with large heads but closed fontanelles, is a sign that an acute hydrocephalus is engrafted upon the chronic condition.

**HODGKIN'S DISEASE AND INTERSTITIAL HEPATITIS.**—Prof. Da Costa has under his care a patient who has had Hodgkin's disease for fifteen years. The disease has been kept in check by living in a

yacht, supplementary to treatment. He strongly urges arsenic, increased in dose until constitutional symptoms are manifested, and kept there, as the best medicinal treatment.

Prof. Da Costa also teaches that in the early stages (before contraction) of interstitial hepatitis (cirrhosis), a cure may be effected, but that after contraction nobody ever recovered. He has seen the disease in women who did not drink, and the worst case he ever had was in a boy four years old, in which the diagnosis was confirmed at the autopsy. Inherited syphilis is a cause of it. In the early stages the remedies are leeches, sulphate of magnesium, cream of tartar, iodide of potassium. —*Col. and Clin. Record.*

**NEW OPERATION FOR CANCER OF THE RECTUM.**—At a meeting of the Société de Médecine of Lyons in May, (*Courier of Medicine*) M. Maurice Pollosson read a paper in which he proposed a modification of the operations hitherto practised for the relief or cure of cancer of the rectum. The establishment of an artificial anus as a palliative measure has long been recommended and practised. By this means the irritant effect of the fecal matter upon the cancerous mass is prevented; the patient is relieved from much suffering, and the cancerous mass being freed from irritation, grows less rapidly.

M. Pollosson adopts this procedure in a modified form as a preliminary step in his plan for radical treatment of this affection. He selects the left iliac region as the site for the operation, because there more readily than in the lumbar region he can close up the lower segment of the bowel, which he regards as a point of essential importance in the operation. This he does by invaginating some millimetres of the lower free end, after dividing the bowel clean across, and obliterating the opening completely by means of five or six cat-gut sutures which thus bring into close apposition the serous surfaces. The artificial anus is completed by suturing it carefully into the wound.

After the patient has recovered from this operation, he proposes to extirpate the cancerous mass which, by virtue of the preliminary operation, is practically removed from its relations as a part of the digestive tract and converted into a pelvic tumor. Operating under the conditions so brought about, it is possible to apply the principles of anti-septic surgery much more thoroughly and efficiently than in the condition existing without such a preliminary operation.

In most cases he believes that it would be advisable to allow the patient to recover from the effects of the first operation before performing the second, though he thinks that circumstances might be such as to make it better to go on at once and extirpate the cancerous mass at once after establishing the artificial anus.

**EPILATION IN PARASITIC DISEASES.**—Although this plan has the sanction of age and custom, it bids fair to disappear as a method of treatment. Dr. Shoemaker, of Philadelphia, in an article which appeared in the July number of the *Journal of Cutaneous and Venereal Diseases*, gives his opinion of this method, and his reasons for discarding it bear the impress of logic and common sense. In the first place as he states, the parasite is not eliminated by epilation, whereas thorough treatment will completely eradicate it, and when it has disappeared the hairs and their follicles will again assume a healthy and normal state. In the next place, he very justly claims that it is well-nigh impossible to epilate diseased hairs, from the fact that they are brittle, break off easily, and, even if successfully taken out, only aggravate the diseased condition of the follicles. Cutting off the hair or shaving it is also a very poor method; for when the applications are rubbed in the scalp the stubby hairs are disturbed to such an extent as to increase the irritation about the follicles. The proper method of treatment is to use parasitocides and avoid all conditions which tend to nourish the parasite. One of the best methods of avoiding the latter is to discard water altogether. Applying water to the skin only renders it in a better condition for the nourishment of a parasite which has lodged there.—*Med. Review.*

**PHOSPHORUS IN TUBERCULAR DISEASE.**—I can quite understand the remarkable success that has attended Dr. Greenway's treatment of tubercular meningitis by phosphorus. Phosphorus is a nutrient for exhausted nerve substance, and it certainly seems a powerful absorbent of recent exudations. Phosphorated oil has even been said to promote the absorption of a cataract if it be rubbed over the eyebrow. In meningitis we have an exudation of yellow lymph at the base of the brain, beneath the arachnoid, and in the web of the pia mater. Prior to absorption lymph undergoes a fatty transformation or solution, and this condition is speedily brought about by phosphorus, for the drug is well known to bring about fatty change in organs. Pathological knowledge therefore seems to point to it as a fitting medicine.

I have employed phosphorus as well as the phosphites of potash and soda, and under the influence of these preparations have seen pleuritic thickenings melt away. Old standing consolidations of the lung that had existed for one, two and three months, I have seen at once begin to move and disperse as soon as the hypophosphite of potash was given; and cases that have appeared to myself and others very much like acute tubercle in the lungs have sometimes recovered on the hypophosphites.

I commenced about twenty years ago with phosphorated oil as a medicine, but owing to its nause-

ous taste I took before long to the use of the hypophosphite salts, which contain phosphorus in a very low state of oxidation; and certainly, in those lung diseases which are of inflammatory exudative origin, and apt to run into phthisis, I know of no remedy to compare with the hypophosphites.

Before the discovery of the tubercle bacillus I had come to the conviction, from observation, that there were cases of lung disease where something seemed most decidedly to stop the way towards recovery by means of drugs given by the stomach. If inflammation be the sole agent that destroys the lung in phthisis, I should regard very few cases as incurable. It is the bacillus that seems to set the phosphorus treatment at defiance, and I notice at Victoria Park Hospital, that just when I find the hypophosphites most helpless, then it is that my clinical assistant finds "lots of bacilli."

A few weeks ago we turned out as cured a case of unmistakable disease of the upper third of one lung, and in that case no bacilli were found.—J. C. Thorowgood, F.R.C.P., in *Brit. Med. Jour.*

**REMEDY FOR RHUS POISONING.**—As this is the season when many persons are making excursions into the country, it is to be expected that there will be many who will suffer from poison contracted by contact with the poison oak. Various remedies have been employed to relieve the suffering thus occasioned, but while one remedy is advantageous to some persons it utterly fails with others. Having learned of a great number of cases in which the fluid extract of serpentaria has been used with remarkable success, I thought it would be well to communicate the fact to your journal, as I have never seen it noticed in medical or pharmaceutical journals. It is best applied by placing cloths moistened with the extract upon the affected parts, without any friction. Two or three applications generally effect a cure.—*Am. Jour. of Pharmacy.*

**SALICYLIC ACID IN THE TREATMENT OF LUPUS.**—I have for some time employed salicylic acid in the form of ointment, as a remedy for eczema of the scalp and impetigo contagiosa in children, with the most satisfactory results, cases that had defied all other treatment yielding rapidly to its agency, and I have been induced to make a further trial of it in other skin affections.

By the kindness of Mr. Rigby, surgeon to the Doncaster Infirmary, I was permitted to employ it in a very bad case of lupus exedens.

The patient, a woman about twenty-five years old, had her face terribly disfigured, the ulceration having destroyed one ala nasi, the whole of the cheek and eyebrow having been involved. She had been in the hospital before, and had improved under treatment with Donovan's solution and a visit to Harrowgate. But on her return, though she was kept under treatment and observation,

fresh tubercles developed, and the parts that had cicatrized soon became again involved, and she was re-admitted to the institution. I first tried an ointment of fifteen grains of the acid to an ounce of cosmoline, which was of no use; I then increased the strength to a drachm, and then to one drachm and a half to the ounce.

The ulcers soon began to heal, no fresh tubercles appeared, the cicatrices became soft and lost their shiny, unhealthy appearance, and the skin of the face is now almost sound. She was previously taking a mixture of Donovan's solution and the liquor ferri dialysati. But as this had been without apparent benefit, I think it fair to give the credit to the external remedy. I have not heard of salicylic acid being employed before in the treatment of this disorder, and its action seems very satisfactory, especially as it does not seem to cause much irritation.—*Brit. Med. Jour.*

**TREATMENT OF FISTULA IN ANO.**—Dr. Poingt claims (*Le Courrier Medical*) that any fistula amenable to treatment by the elastic ligature may be cured by simple drainage of the fistulous tract. The drainage tube is to be inserted by means of a stylet passed up the tract from the external opening. At the end of two or three weeks the drainage-tube falls out, after having destroyed the superficial wall of the fistula. A granulating surface of small extent is left, which rapidly heals by cicatrization. The procedure is wholly painless, and the patient may pursue his ordinary avocation during the entire course of treatment. The operation is never followed by any of those serious complications sometimes seen after the cutting operation.—*Southern Clinic.*

**THE NUMBER SEVEN.**—Hippocrates believed there was "luck in sevens," and he, like Shakespeare, divided the life of man into seven stages, holding that the number seven is the fountain of all the changes in life. For instance, the teeth appear in the seventh month or sooner, and are shed and renewed in the seventh year, when infancy is fully changed into childhood. At twice seven years puberty begins. At three times seven the adolescent faculties are developed, manhood commences, and men become legally competent to complete civil acts. At four times seven man is in full possession of all his strength. At five times seven he is fitted for all the business of the world. At six times seven he becomes wise, if ever. At seven times seven he is in his apogee, and from that time decays. At eight times seven he is in his first climacteric. At nine times seven he is in his last or grand climacteric, and at ten times seven he has approached the normal period of life.

There are some remarkable septenary coincidences in the discharge of physiological functions, and in disease processes. The human female men-

struates in four times seven days, and in forty times seven days she gives birth to her child. The period of gestation in animals is, in many if not in all instances, a multiple of seven. In the dog it is nine times seven days; in the cat, eight times seven; in the fox, six times seven. The common hen sits on her eggs three times seven days; the duck and goose, four times seven; the crow, three times seven; the swan, six times seven; the peacock, four times seven; the canary and pigeon, twice seven. Bees hatch out in three times seven days. Fever and ague has a tendency to terminate spontaneously after the 7th, 14th and 21st paroxysms. Relapsing fever is a disease of seven days' duration. Typhoid fever lasts three times seven days. The incubation of measles is twice seven days, and the disease itself lasts seven days—three days of catarrh and four of eruption—before it declines. Scarlet fever and erysipelas occupy seven days. Small-pox requires twice seven days—from the time of the appearance of the primary fever and the full development of the eruption, seven days, and in seven days more the whole crop of pustules has been converted into desiccated scabs. Truly, there is something wonderful about the number seven.—*Med. Age.*

**DOCTOR'S MISTAKES.**—At the recent meeting of the Kentucky State Medical Society, a number of the members grew quite confidential, and related, when in that mood, some experiences which it is not customary to see recorded in the public prints. For instance, Dr. Stone told of a German woman, the mother of three children, whose case was pronounced to be one of simple ascites. Several physicians, among whom was a distinguished professor of surgery, saw the case, and the latter used the sound and speculum to verify his diagnosis, preparatory to the operation which he contemplated performing for the removal of the left ovary. The manipulation excited some contractions of the uterus, during which a large clot of blood was expelled. After these symptoms passed away, an able obstetrician and professor, and an author of national reputation, was called in, with a view to making the diagnosis doubly sure. He, too, examined with sound and speculum, and diagnosed the existence of two tumors, one the enlarged and subinvolved uterus, the other of doubtful character, probably cystic, developed within the broad ligament. The sound, when withdrawn, as in the previous examinations, was covered with blood, and pains came on soon afterwards. In fifteen minutes, a clot of blood and three pints of water passed from her vagina, and a few hours later the woman gave birth to a six and a half months' child, which lived till morning and died.

Dr. Vandell, of Louisville, related several experiences which, recorded in detail, would make quite as interesting a report as that by Dr. Stone. He



knew of two or three such cases as that reported by the doctor. Prof. Miller and Prof. Baylis diagnosed an abdominal tumor to be ovarian, and not until the woman gave birth to a child did they discover their mistake. Some years afterwards a woman came up from Mobile. She had a tumor. She was a widow. Parvin saw it, Miller saw it, Thomas saw it. All declared it to be a fibroid. In the fall she gave birth to a child. Dr. Y. saw a case four years ago of an enormous tumor pronounced by Parvin, Gross and other eminent men, with himself, to be a fibroid. The woman was put on muriate of ammonia and ergotine. One night, after about three years of such treatment, she was seized with all the symptoms of peritonitis, collapse and shock. She was tapped, and an enormous quantity of fluid was drawn off. The cyst refilled. Dr. Yandell operated on her afterwards for its enucleation, and while the operation was as easy as it was possible to do, the woman died.

Such cases show simply that the wisest and most experienced of us make mistakes.—*Med. Age.*

**RECTAL FEEDING AND MEDICATION.**—Dr. Wm. Julius Mickle gives some very useful hints in a paper on this subject published in *The Journal of Mental Science*. In using nutrient enemata he advises that : Alcohol should not be added to albuminous food. If necessary, the bowels should previously be cleared out by a simple or aperient clyster, and a daily copious cleansing clyster is required in some instances. The bowels may have to be rested, but we must persevere if the first attempt fails. Where it is apt to return, the patient's best position to receive the enema is on the back or left side. The nozzle or tube should be comfortably warm, so should the food injected. The amount injected may sometimes with advantage be small at first, gradually increasing from 2 to 10 ozs. If the foods are ejected, we may try the plan (Dr. Hine's) of depositing them higher up in the viscous by means of elastic tubing and a funnel. But plugging the anus is often necessary, and has been done in many cases. Conflicting as are the results of experiments on the subject, he concludes that the rectum and colon digest but little, and that, even when inverse peristole is set up, the action of the bowel upon enemata is chiefly absorptive. If so, the food should either be introduced mixed with digestive substances, or else before administration should in some way or in some measure be digested, and ready for absorption into the venules and lymphatics of the intestinal walls.

The following methods are all considered good :  
*Leube.* Three parts of meat to 1 part of pancreas, both finely minced and mixed with a sufficient quantity of warm water for clysis. Carefully remove all fat and connective tissue. The hog's pancreas is the favorite.

*Rennie.* To a basin of good beef-tea, add  $\frac{1}{2}$  lb.

shredded lean raw beef ; 3j fresh peps. porci ; 3ij dil. hydrochloric acid ; warm for four hours, stir frequently. Beaten egg or alcohol (?) may be added.

*Catillon.* A saturated solution at 19° C. of pepsine of meat, 40 grammes ; water, 125 grammes ; laudanum, 3 to 4 drops ; bicarb. of soda, 3 centigrammes.

*Dobell.* Cooked, finely grated beef or mutton, 1 lb. ; pancreatic emulsion, 1 oz. ; pancreatic powder, 20 grs. ; pepsine (pig's), 20 grs. Mix quickly, add half an ounce of brandy, and warm water sufficient to bring it to the consistence of treacle.

*Henninger.* Very lean meat, finely minced, is placed in a glass receiver : water and hydrochloric acid are poured on, and pepsine, at the maximum of its activity, is added. The whole is left in a water-bath or stove to digest for 26 hours at 113° F. ; it is then decanted into a porcelain capsule, brought to the boiling point, and whilst the liquid boils a sol. of sod. carb. is added to it, until it shows a very slight alkaline reaction. Then the boiling liquid is passed through a fine linen cloth. The liquid is reduced in bulk in a water-bath. White sugar is added before administration.

*Mickle.* A pint of milk, with one-fifth or one-fourth of a pint of water, is carefully heated to 140° F. Two drachms of liquor pancreaticus and 20 grains of bicarbonate of sodium in one or two ounces of water, are added. The whole, in a covered vessel, is kept near the fire at 140° F. for an hour or an hour and a half, then thoroughly boiled for two or three minutes. Thus prepared the food keeps for half a day or a day.

Dr. Mickle uses enemata of chloral hydrate in many cases of epilepsy and of epileptiform seizures. He gives thirty grains dissolved in two ounces of water, and has found it very useful.

**THE NEW HYPNOTIC.**—If paraldehyde should prove as reliable as the reports thus far published seem to promise, we have in it a really valuable hypnotic. The latest observer is Dr. E. Kurz, who in the *Gentrlb. f. d. d. Med.* (18, 1884), gives the results of his experiments with the remedy on twenty-four cases. With few exceptions the effect was favorable. Usually he administered the drug in the dose of three, sometimes four grams (gr. i. to gr. lxx.) and in watery solution. But in this manner taken the remedy has a very disagreeable taste, and Dr. Sutter, of Illenau, recommends rum as a medium. Paraldehyde is incorporated in sugar, so that in the form of troches, one of these contains sixteen grains. Three or four of them, according to Sutter, are then dissolved in rum and a few drops of essence of lemon added. Thus prepared, the disagreeable taste is utterly concealed, and the patients do not object to take it. Its administration in *refracta dosi* is not so reliable as the effect of a single large dose. In most of K's twenty-four cases

insomnia had been complained of for a long time, and had not yielded notwithstanding the use of narcotics.

We will mention some of the diseases in which it was employed by K. for sleeplessness:

1. Phthisis, after repeated administration of paraldehyde, prompt effect.

2. Insomnia, with great restlessness after several days of railroad travel: perfectly quiet sleep restored after first dose.

3. Large ulcerated carcinoma of the mamma: after the pains had been subdued by hypodermic injections of morphia, sleep was induced by paraldehyde. Morphia and cannabis indica had not been effectual, and chloral had caused only excitement.

4. Insomnia, after violent psychical excitement: chloral had here also caused sleep, but been followed by severe headache; effect of paraldehyde instantaneous.

5. Mitral insufficiency with severe dyspnoea: neither morphia, cannabis, nor chloral caused sleep; paraldehyde did so, but partially.

6. Insomnia after typhus: morphia produced excitement; cannabis was useless; paraldehyde acted promptly.

7. Acute melancholy: prompt effect.

8. Insomnia in childhood: paraldehyde caused a quiet slumber.

9. Intra-orbital neuralgia: paraldehyde induced sleep but the effect of cannabis was still better.

The same was noticed in a tenth case, where chronic otitis had produced the sleeplessness.

Of the twenty-four cases but four evinced no or but partial hypnotic effects from the remedy. The opposite effect, excitation, as often observed from morphia and cannabis, was not seen in any case in which paraldehyde had been employed. Sleep generally set in within thirty minutes, and lasted from five to seven hours. Even in the few cases in which no hypnotic effect ensued, the patients admitted having felt much quieter after the paraldehyde; pulse became slower and arterial tension lessened, if previously increased; disagreeable effects were never noticed.—*Med. and Surg. Reporter*.

**HAZELINE IN MENORRHAGIA.**—According to Mr. Henry M. Chute, menorrhagia is a very frequent ailment of women in Cape Colony. He has found a valuable remedy for it, he says, in the extract of American witch hazel (*Hamamelis virginica*) or hazeline, in doses of half a teaspoonful, in sugared water, twice or three times a day. Mr. Chute states that it acts so quickly that it is not necessary to anticipate the flow, but when menstruation, after it has lasted the ordinary time, is not closing naturally, hazeline given as above will effectually restrain it, and after hæmorrhage has ceased there is no advantage in continuing it. While thus taken, some patients have mentioned that they have a

pleasant sense of exhilaration, of being strung up, and have lost that wearying sense of languor felt at these times. Another good result hazeline produces is that, when there is dysmenorrhœa, it in a very quick and marked way relieves the pain. Mr. Chute mentions the case of a young lady who suffered severely—so much as to necessitate her keeping in bed, and who was once so bad as to require a hypodermic injection of morphia. Since she has taken hazeline, menstruation has been painless and not excessive as formerly.—(*South African Medical Journal*, Feb. 15, 1884.)

**PILOCARPINE FOR DEAFNESS.**—For all recent cases of deafness due to labyrinthine disturbances, whatever the primary cause may have been, Politzer tries the subcutaneous injection of a two per cent. solution of muriate of pilocarpine. He injects four drops at first, and gradually increases the dose to ten drops daily. He gets fairly good results in about one-half of the cases. I have seen three cases of persons totally deaf, who, after being treated in this way, could hear and understand loud speech spoken at the distance of a few inches from the ear; and Politzer has had one case of perfect recovery of the hearing after it had been absent for three years, and several other very satisfactory results following the use of this drug. He is about to publish the results of his experiments with the history of some of the cases. It is not known how pilocarpine acts in these cases, but the benefit derived from its use is certainly great in some of them.—*Boston Med. and Surg. Journal*.

**NEW TREATMENT OF LUPUS.**—Dr. Vidal (*Jour. de Méd. de Paris*) proposes a new method, viz., that of ether injection, to cause suppuration. He uses the common hypodermic syringe (Pravaz's), and injects from 5 to 20 drops for each injection, according to size of lupus. The injections are continued until pus formation is indicated by the fluctuation. The abscesses are then opened and the pus discharged, after which it is claimed healing takes place and the lupus disappears.

**NEURALGIC DYSMENORRHEA.**—Professor Parvin (*Coll. and Clin. Record*) recommends the following for neuralgic dysmenorrhœa:

R—Tinct. opii,

Tinct. valerianæ,

Spirit ætheris comp.,

Tinct. castorei, aa f. 3 ij.—M.

Sig.—A teaspoonful every hour.

**CHRONIC BRONCHITIS WITH ASTHMATIC PAROXYSMS.**—Prof. Bartholow recommends Potasii iodidi, grs. xx., Liq. potasii arsenitis, gtt. ij.—Mix. Take every four hours during the paroxysm, and in the intervals between the attacks, ammonii iodidi, grs. v-x.—*Med. Bulletin*.



# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. McMillan, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MARLBOROUGH, 23 Rue Richer, Paris.

TORONTO, OCTOBER, 1884.

*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## OVER-EATING AND UNDER-EATING.

We cannot imagine a closer connection between any two things than that which exists between life and nutrition. The continuance of life is dependent on the continued supply of nutrition. Even the quality or kind of life, speaking of life in an unrestricted sense, is largely influenced and moulded by the quantity and quality of nutrition supplied. Consequently we notice variations in the form and life of the plant, or the individual, according as nutrition has been normal, insufficient, or in excess. Every living thing calls for its own peculiar and natural supply, and flourishes best when a normal standard is regularly maintained. Insufficiency and superfluity of food are both usually followed by marked departure from the normal life standard. No one need be told that insufficient alimentation, in both kingdoms, is followed by a train of consequences very much similar—that the plant, or the individual, soon shows loss of health and vigor, gradually diminishes in size, and if the process of decay is permitted to proceed, finally dies. Owing to the more complex nature of the organs of assimilation in animals, and other causes needless to mention, the results of excessive alimentation are not so uniform in their operations as those of insufficient alimentation, as applied to the two kingdoms. There may be, and doubtless there are exceptions, still the rule is, even in the vegetable kingdom, that excessive alimentation is an evil to be avoided. The over-nourished wheat-stalk grows

coarse and rank, but the grain is either wanting or is poor in quality. The rule more than holds its own when we ascend to the animal kingdom. Every one must be aware that even brutes suffer harm from over-feeding. But it is not till we arrive at man, that we witness all the baneful consequences of excessive alimentation.

An honored teacher of medicine, the late Dr. Rolph, used to say to his class: But few eat too little; most eat too much. The truth of that laconic remark is known to every observant person. We all know that the largest eaters are not necessarily the largest nor strongest of the race. The very opposite is nearer the mark, notwithstanding a few notable exceptions. No homely aphorism was ever truer than this one: "He eats so much that it makes him poor to carry it." It is a fact that a large majority of the lean and sickly amongst us are immoderate eaters, while a majority of the healthy and robust are moderate, or small eaters. The reason of this is easy to find. He who eats more than nature demands, imposes a heavy strain on the organs involved in the process of digestion and elimination. The stomach has a more or less definite digestive capacity, which if unduly overtaxed results in imperfect digestion, impure blood, disordered function, and gradual decay. Just as certain as we exceed the natural bounds set by nature, and overtax our stomachs to please our palates, so surely do we begin to sow the seeds of disease. True, the stomach is elastic, and marvellously accommodating, and bravely resists the assaults imprudently made on its inherent rights; but like the stone, under continued dropping, it gradually wears out.

While no reasonable person will take exception to these remarks, it is open to question, whether medical men generally are so impressed with the importance of the truth they embody as its importance merits. We hear a great deal said about "abundance of nourishing food," but very little about over-abundance. If the patient be reduced in flesh, it is too readily assumed that what he most needs is plenty of beef and other good things, while the truth may be that he has been by far too well supplied all along. Let any medical man keep a record of those chronically affected who apply to him for relief, and he will soon find that the vast majority of them have good appetites—too good in fact, and eat "abundance of nutritious food." He will find that the vast majority of this class of pa-

tients are suffering from troubles of the digestive organs, not secondarily but primarily. They are living witnesses of the literal truth of the saying, before quoted, "he eats so much that it makes him poor to carry it." For the physician to recommend a continuance of an over-generous diet under these circumstances, is to aggravate the evil. Even in the case of the under-fed it may be improper to do so, for in a weakened condition of the system it is easy to overtax the organs of digestion and so defeat all attempts at striking at the root of the malady. That physician who best excels in gauging the wants of the system and its power of assimilation, will be most successful in the cure of disease.

We do not contend that there are no under-fed or starved people in the world, or no ailment traceable to this cause. Unhappily there is too much of both. Still, outside the great centres of population, the number of the debilitated and diseased from lack of food is small, in this country. Happily for our people they have a goodly heritage, where food is both abundant and cheap, and easily obtainable by all who are able to work for it. This great and inestimable blessing is not unmixed with evil. A well laden table is sure to lead to over-indulgence, and hence we find in this country, and amongst our neighbors, more dyspeptics than can be found in all the world besides. Let over-indulgence be discontinued and the saving thus effected given to the poor, and two classes shall speedily and simultaneously disappear—the dyspeptic and the hungry.

#### THE CANADA MEDICAL ASSOCIATION.

The seventeenth annual meeting of the Canada Medical Association was held in Montreal on the 25th, 26th and 27th of August, and was largely attended. To say that this was by far the most successful meeting in the history of the Association is but to express the simple truth. A number of the members of the British Association for the Advancement of Science not only honored the meeting with their presence, but also took an active part in the proceedings, and gave increased interest and zest to the discussions. The papers were upon the whole very good, and were in most instances fully discussed. The event of the meeting was of course the address on "Abdominal Surgery," by Mr. Lawson Tait, of Birmingham, which will be found in another column. He was accorded a very

enthusiastic reception, and the address was received with marked attention. He is a man of fine presence, speaks with a slightly Scotch accent, has a good style of delivery, and speaks with the confidence of a man who knows his subject thoroughly. The discussion which followed was also very interesting and instructive. Among those from abroad who took an active part in the proceedings may be mentioned, Drs. Protheroe Smith and his son Heywood Smith and Dr. Harley, of London; Dr. Struthers, of Aberdeen; Dr. McMillan, of Hull; Drs. McGrath and Brodie, of Detroit; Dr. Brush, of Utica; Dr. Elsberg, of New York, and others.

The Association, as in former years, was divided into two sections—Medicine and Surgery. Dr. Thorburn, of Toronto, was appointed chairman of the former, and Dr. Roddick, of Montreal, chairman of the latter. The sections met in the afternoons and evenings, and the forenoons were devoted to the general work of the Association.

The President's address consisted of a brief review of the founding of the Association and the general progress of medical science and medical education in Canada. He took occasion to praise our one-portal system of licensing in Ontario and expressed the hope that the sister Province of Quebec might soon follow in our wake, and that ere long we might have one portal for the entire Dominion. An epitome of his address will be found among the proceedings.

The profession of Montreal, so noted for their hospitality to strangers, far exceeded any previous effort in this direction, and the occasion will long be remembered by those who participated. The banquet at the Windsor was a most magnificent spread, the large dining hall being filled with guests. About two hundred sat down to dinner, among whom were a goodly number of the members of the British Science Association, both medical and lay. Dr. Hingston presided and acquitted himself in his usual happy manner, and was ably supported by Drs. Grant, F. W. Campbell, T. Rodger and Roddick in the vice-chairs. The after-dinner speeches were very good and a pleasant evening was spent by all who had the good fortune to be present.

Dr. Osler was unanimously chosen President for the ensuing year, and Winnipeg selected as the next place of meeting, on the third Tuesday in August, 1885.

### MEDICAL MEN'S FEES.

A test case was recently tried in Belleville, Ont., to determine whether or not a patient is liable for the fees of a medical man who is called by a friend or relative. In this case the brother of the patient summoned the consulting physician, who assisted in the amputation of a finger. The patient refused to pay the consulting physician on the ground that he had not engaged him, and told him to look to the attending physician for his fee. The Judge who tried the case ordered a non-suit, holding that the patient was responsible only to the physician he engaged. We are a little surprised at the ruling of the Judge in this case, as we had always entertained the idea that if the patient accepted the services of a physician, he was bound to pay him. It is a well-recognized principle among the medical profession that when a medical man is called in consultation the patient is responsible for the payment of the fee. In view of the Judge's ruling in this case the question might well be asked, Who is to be responsible for the fees where the patient is unconscious and incapable of engaging anyone? One not versed in the intricacies of the law would naturally suppose that a patient's brother could safely be considered an authorized agent to engage the services of a medical man, but such it seems is not the case. And if a patient is not responsible for the fees of a medical man who has been engaged by his brother, what are the chances of having a legal claim to remuneration for services rendered when the party who calls the physician is only a neighbor, a friend, or, in case of emergency, possibly a stranger?

**MALPRACTICE SUIT.**—A suit to recover \$2000 damages for alleged malpractice was recently tried in Walkerton, Ont. The plaintiff, Mr. Robertson, received a fracture in the lower third of the thigh in November last, and the defendant, Dr. H. A. Bonnar, of Chesley, Ont., was called to treat him, which he did in the usual way by means of a weight and pulley, together with the use of coaptation splints. The treatment was continued eight weeks and upon examination there was found to be  $\frac{3}{4}$  of an inch shortening, besides a considerable degree of angular displacement at the seat of fracture. There was also some stiffness of the knee joint.

The plaintiff alleged that the defendant had not treated the fracture properly, and also that he allowed him to use his limb before union had taken place. The plaintiff's views were supported only by the evidence of Dr. Cooke of Chesley who was called in to treat the patient after Dr. Bonnar had discontinued his attendance. For the defence it was shown by Drs. Fulton and White of Toronto and several other medical gentlemen in the locality, that Dr. Bonnar had treated the plaintiff skillfully and carefully, and was not in any way to blame for the result. The shortening was not more than the average in fracture of the thigh, and the deformity did not interfere with the utility of the limb. At the close of the plaintiff's case the Judge said there was no evidence to go to the jury as to the allegation that the method adopted by the doctor was an improper one, as it had been proved to be a method sanctioned by the highest authority. He would have to leave the other portion of the case to the jury, as to whether the doctor had carefully attended his patient and to say whether the result had been what might naturally be expected if the plaintiff had been properly treated, even assuming the method adopted to be a proper authorized one. The jury failing to agree were discharged. We congratulate Dr. Bonnar on the result of the trial.

**ONTARIO MEDICAL COUNCIL ELECTIONS.**—The following gentlemen have been recently nominated as candidates for the Erie and Niagara Division in the Medical Council, viz.: Dr. Philip, of Brantford, and Dr. Thos. T. Harrison, of Selkirk. With one or two exceptions the old members will be candidates for re-election, and as they were for the most part faithful to their trust, we hope to see them returned. We give the following extract from the by-law for conducting the elections which take place on the 4th Tuesday in May, 1885:

"Any member presenting himself for election as the Representative to the Medical Council for a Territorial Division, must receive the nomination of at least ten (10) registered practitioners resident in such division, and such nomination paper must be in the hands of the Returning Officer for the division not later than 2 o'clock on the afternoon of the first Tuesday in May, 1885. The Registrar shall send to every registered member of the College, entitled to receive the same, a voting paper,

(in accordance with residence given on the register), by the second Tuesday in May, 1885. Any member of the College not having received a voting paper, when more than one candidate has been properly nominated for his division, will send by post to the Registrar his name and address."

**GUN-SHOT WOUNDS OF THE INTESTINES.**—Dr. Parkes, of Rush Medical College, Chicago, has been experimenting on gun-shot wounds of the intestine in dogs, and gives the result in a paper read before the Am. Med. Association. The experiments show in the most unmistakeable manner the utility and value of abdominal section, and stitching of the bowel. He recommends a modification of the *Lembert* suture, as the most satisfactory, but states in conclusion that it makes no difference what kind of suture is used, so long as the principle of securing the application of two broad surfaces of peritoneum in contact with each other is carried out. He used both silk and catgut. The sutures were introduced about the third of an inch from the divided edges, made to include the peritoneal and muscular coats *only*, and brought out just free of the edge on one side, and similarly inserted on the other. The lacerated part was first excised and bleeding arrested.

**LIGATURE OF THE COMMON CAROTID.**—Dr. W. Honeywell, of New Glasgow, P.E.I., with the assistance of Drs. Toombs and Gallant, of Cardigan, successfully ligated the common carotid, below the cricoid cartilage, a short time ago. The patient, a sailor, fell down stairs in a vessel on a piece of earthenware, which penetrated his neck below the under jaw, making a ragged wound about two inches deep and wounding the external carotid. The usual incision was made along the anterior border of the sterno-mastoid, and the vessel tied with a prepared violin string (this was kept in oil of juniper for six weeks, then put in alcohol). The wound was washed out with a solution of corrosive sublimate (1 to 2000) then covered with iodoform gauze. It healed by first intention, and the patient recovered without a bad symptom, except a little vertigo.

**PONTIAC COUNTY ASSOCIATION, QUE.**—The members of the medical profession of this county, met at Portage du Fort on the 12th ult, for the purpose of organizing, revising the tariff and dis-

cussing matters appertaining to the fraternity. There was a good attendance present. Dr. Purvis was elected *President*, Dr. Lyon *Vice-President*, and Dr. Knox, *Sec.-Treas.*

A tariff of fees was considered and adopted. The annual fee to defray the expenses of the association was fixed at \$1. The association will meet three times in the year, on the second Tuesday of May, January and September. As there are a few medical men practising in the county without licenses it was unanimously agreed that proceedings be taken against them forthwith. The next meeting of the association will be held at Shawville.

**COLORADO BEETLES IN THE STOMACH.**—Dr. Harrison, of Keene, Ont., sends us the following: On July 9th, a child two years old was brought to his surgery very ill. The symptoms were indicative of intestinal and alimentary irritation, with tendency to stupor. He was doubtful about the cause, but thought it might be due to worms or something the child had eaten. He gave some powders of *santonine*, *aloine*, etc. Two days after the parents were amazed and alarmed at seeing the child pass a large quantity of Colorado beetles in the pupa state. The child continued to improve steadily as soon as rid of the offenders. Strange to say they did not appear to be the least inconvenienced by their sojourn in the child's stomach.

**APPOINTMENTS.**—The following gentlemen have been appointed examiners under the Civil Service Acts, 1882 and 1883:—Drs. M. Sullivan, Kingston; C. J. Samson, Quebec; P. Conroy, Charlottetown, P. E. I.; J. B. Matthews, Victoria, B.C.; W. Canniff, Toronto; and Dr. Codd, Winnipeg.

Dr. C. W. Belton, has been appointed medical superintendent of the London General Hospital, *vice* Dr. Wilkinson resigned.

Dr. Bruce, of Woodstock, N. B., has been appointed on the staff of the St. John Public Hospital, *vice* Dr. Coleman, who is about leaving the city.

**ERGOT IN CHOREA.**—The value of ergot in many affections of the cerebro-spinal system is well known. On the assumption that the smaller vessels of the brain, as Dr. Dickinson maintains, are in a state of dilatation, Dr. Forrest (*London Lancet*) has been experimenting with this remedy in

chorea. He began by giving the fluid extract in five minim doses, and the results have been on the whole satisfactory.

**TREATMENT OF GONORRHOEA.**—The following suggested by a retired army surgeon is going the rounds of the press as a cure for gonorrhœa—

R Zinci sulph.

Ext. Belladonnæ aa grs. xx.

Mucilag acaciæ ʒi

Aquæ ad. ʒviii.—M.

Sig.—A teaspoonful to be injected frequently. An ointment of opium, and belladonna also to be smeared along the perineum and crus penis at night.

**HALDIMAND COUNTY MEDICAL SOCIETY.**—At a meeting of the above-named society held in Caledonia on the 19th ult., the following officers were re-elected, viz.: Dr. Dee, *President*; Dr. Davis, *Treasurer*; and Dr. Forbes, *Secretary*. On motion of Dr. Harris, seconded by Dr. Baxter. Dr. Harrison, of Selkirk, was nominated for election to the Ontario Medical Council (1885) for the Erie and Niagara Division.

**ARREST OF TUBAL PREGNANCY.**—Dr. Mundé, of New York, reports in the *Medical Record* a successful case of arrest of tubal pregnancy by galvanism. One electrode was placed in the rectum and the other over the mass, and the strength of the current gradually increased to 24 cells. The patient though much prostrated at the time made a good recovery.

**PROFESSIONAL EXAMINATION.**—The following gentlemen have passed the supplemental examination for M.D. C.M. in McGill College. D. A. Cameron, Strathroy, Ont.; J. T. Mackenzie, Belleville, Ont.; J. A. McArthur, London, Ont.; and J. C. Sharpe, Sussex, N.B.

Dr. Lawson Tait, contrary to his original intention, has been doing some operative surgery on this side the water. In Hamilton, he opened the abdomen for supposed gall stones, but found carcinoma instead. In Albany and New York he performed three operations for removal of the ovaries and one hysterectomy.

**PERSONAL.**—Dr. Osler of Montreal was entertained by the Toronto Medical Society on the 25th

ult. prior to his departure for Philadelphia to enter upon his duties as Prof. of Clinical Medicine in the University of Pennsylvania.

**ADMINISTRATION OF IRON.**—To prevent the disturbance of the stomach, occasioned by tincture of iron, it should be combined with muriate of ammonia in the proportion of one part to two of the tincture. This also renders it more palatable.

**PRURITUS.**—The latest remedy for this troublesome affection, when seated in the anus or vulva is balsam of Peru. The *British Medical Journal* alludes to it as a new triumph in medicine.

The *Lancet*, September 20th, contains a notice of the death of Dr. Radcliffe, whose name has been so long associated with public health matters in England.

The next meeting of the International Medical Congress, as was anticipated in our last issue, will be held in Washington in 1887.

**BRITISH DIPLOMAS.**—Drs. T. McCullough and J. E. Brown (Trinity) have successfully passed the required examination for the L.R.C.P. Edin.

THE death of Prof. Cohnheim, of Leipsic, is announced in our foreign exchanges.

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### Books and Pamphlets.

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A MANUAL OF DISEASE OF THE THROAT AND NOSE, including the Pharynx, Larynx, Trachea, Oesophagus, Nose and Naso-pharynx, by Morell McKenzie, M.D., Lond. New York: Wm. Wood & Co. Toronto: Hart & Co.

This is the second volume of the above-named work, embracing the "Diseases of the Oesophagus, Nose and Naso-pharynx," and constituting the August number of Wood's Library of Standard Authors. It is nearly twelve years, the author states, since the work was commenced, and during that time there is scarcely a page that has not been written and re-written many times. He has been at great pains to make the work a faithful exponent of the science and practice in this important department of medicine. The work bears evidence of the care and attention which has been bestowed upon its

preparation. The reputation of the author as a specialist in this field is too well known to require any notice at our hands.

A PRACTICAL TREATISE ON DISEASES IN CHILDREN, by Eustace Smith, M.D., F.R.C.P. Lond., Physician to the East London Children's Hospital. New York : Wm. Wood & Co. Toronto : Williamson & Co.

The opportunities of the author as well as his reputation as a practitioner, entitle his work to the favorable consideration of the profession on both sides of the Atlantic. The author discusses the whole subject of disease in early life, and deals with it purely from a clinical standpoint. Each subject has been treated very fully, and great care has been bestowed on the sections relating to diagnosis and treatment. Due prominence has also been given to the important subjects of diet and hygiene. Many interesting cases from the author's case-books, by way of illustration, have been introduced into the text. It is the most complete work of the kind in the English language, embracing in 12 parts the following : Acute infectious, non-infectious, diathetic, glandular, nervous, respiratory, circulatory, mouth and throat, digestive, hepatic, genito-urinary, and skin diseases. We commend the work to the Canadian profession.

THE POPULAR SCIENCE MONTHLY for September, 1884. New York : D. Appleton & Co. Fifty cents a number, \$5 a year.

The frontispiece of the September "Popular Science Monthly" is a fine portrait of Professor J. P. Lesley, chief geologist for Pennsylvania, and President of the American Association for the Advancement of Science. Prof. J. P. Cooke's article (Harvard University) on "Scientific Culture : its Spirit, its Aim, and its Methods," is an able exposition of this subject. In "National Health and Work," Sir James Paget strikingly presents an additional reason for sanitary activity in the loss which results to the nation from the sickness and early death of its workers. Among other articles may be mentioned : "Sorghum as a Source of Sugar," "Hygiene for Smokers," "Sun Kinks," "The Problem of Population," "Protection against Lightning," etc. The editor writes on the meetings of the British and American Associations, and discusses a recent article by Bonamy Price, under the heading, "The College Feitch once more."

A MANUAL OF OBSTETRICS, by Ed. L. Partridge, M.D., Prof. of Obstetrics New York Post-graduate Medical School, etc., with sixty illustrations. New York : Wm. Wood & Co. Toronto : Williamson & Co.

This is a very convenient pocket manual, and as such will be found useful by young men commencing practice, for reference in perplexing cases at the bed-side. The author has given a very concise and correct outline of this important subject, and medical students will find it valuable in making readily available their store of knowledge in a professional examination.

MANUAL OF AUSCULTATION, PERCUSSION AND URINALYSIS, ILLUSTRATED. By C. Henri Leonard, M. A., M. D. Detroit : Illustrated Medical Journal Co.

This unpretentious little work contains a complete epitome of the physical signs of the heart, lungs, liver, kidney and spleen in health and disease. The matter is so condensed that a great deal of information is compressed into a very small compass. The illustrations are fairly good and the text clear and explicit. Dr. Leonard is quite an adept at this kind of work, having already published several of like nature, such as "Vest-Pocket Anatomist," "Reference and Dose Book," "Bandaging," "Hair and its Diseases," etc.

THE CARE AND FEEDING OF INFANTS, by Doliber, Goodale & Co., Boston, Mass.

This pamphlet, which deals with the essentials of feeding infants, invalids, etc., will be sent free to any address on application.

VISIONS OF FANCY. A poetical work, by N. M. Baskett, M.D., of Moberly, Mo. St. Louis, Mo : Commercial Printing Co.

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## Births, Marriages and Deaths.

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At Moorefield, Ont., on the 14th ult., Dr. Henry Mandesley, aged 54 years.

At Arichat, N. S., on the 13th ult., Henry C. Fixott, M.D., M.R.C.S., Eng., aged 64 years.

On the 25th ult., Dr. Edward Morton of Queensville, Ont.

On the 11th ult., Dr. G. A. Kent, of Wallace, N.S.

# THE CANADA LANCET.

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## Original Communications.

### THE EFFECTS OF TOBACCO.\*

BY W. F. COLEMAN, M.D., M.R.C.S., ENG., ST. JOHN, N.B.

*Mr. President and Gentlemen,*—At our last meeting the President referred to a case of faint cardiac murmur in a very healthy man who smoked a good deal, and questioned as to the possible connection between the tobacco and the murmur. This suggested to me "The Effects of Tobacco" as a subject for this evening's consideration. In regard to one field of observation, I have a very decided view, and am anxious to get the benefit of your experience in a more general field. The universality of puffing and chewing the fragrant weed, and the potency of tobacco as a poison, make the question of the effect of its habitual or remedial use an important one. Tobacco belongs to the family solanaceæ, which embraces such members as hyosciamus, belladonna, stramonium, and curiously enough, the potato. Its important active principles are a colorless liquid alkaloid, called nicotine, a poison "which almost equals hydrocyanic acid in activity" and a camphoraceous volatile oil, nicotianin. By burning tobacco, an empyreumatic oil is produced from the decomposition of some of its constituents, which as found in the pipe of the smoker, is an active poison, and appears to be (Christison says) nicotine attached to a true volatile oil. The proportion of nicotine varies in different sorts of tobacco, and the quantity usually present is by various chemists estimated from 2% to one part in ten thousand. Two or three drops of nicotine or 3ss. of tobacco may cause death. The death of two brothers is reported from the continuous smoking of 17-18 pipes. Pereira gives a case in which twelve drops of an infusion of tobacco given as an enema caused death.

Von Boeck on vegetable poisons, says, "It is from smoking tobacco that nicotine poisoning chiefly arises, the smoke itself containing the nicotine. A great deal of it accumulates on the lower part of the pipes, and the remains of cigars are much more impregnated with it than the parts fresh smoked. Large poisonous doses of tobacco are said to produce syncope, small pulse and labored respiration. In most cases convulsions supervene. The pupils are at first dilated, then contracted. There is prolonged collapse and finally death."

Erb, of Heidelberg, says: Various authors adduce excessive tobacco smoking among the causes of tabes dorsalis. I would here say, in anticipation, if we can prove, as we think possible, that tobacco smoking often produces inflammation and atrophy of the optic nerve, is it not more than probable that it can and does produce myelitis, followed by atrophy of the cord, the admitted pathology of tabes dorsalis. Beau describes eight cases of angina pectoris, in which the attacks ceased when smoking was stopped, and returned when the patients began to smoke. Headland places tobacco under the class neurotics, order inebriants. The observations of Claude Bernard that nicotine at first produces contraction of the arteries, and later on the vessels become distended, agree with the results of the physiological researches of Uspensky, who concludes that nicotine first stimulates then paralyzes the vaso-motor centres.

From personal experience and the literature at my command, I know of no more constant detrimental effect of the abuse of tobacco than impairment of sight, ranging from slight defect to total blindness. The abuse of tobacco is so frequently associated with drinking to excess, that it is questioned by some whether tobacco alone ever produces impaired sight, or whether the tobacco or alcohol is the chief factor. My own opinion is, that tobacco alone is quite able to produce imperfect sight. Dr. Webster, of New York, in an able paper reporting twenty cases of amblyopia from the abuse of alcohol and tobacco, remarks, "That the abuse of alcohol alone, or of alcohol and tobacco combined, may produce impairment of vision, no physician acquainted with the subject will, I think, venture to deny. Some, however, doubt that tobacco alone ever causes impairment

\*Read before the New Brunswick Medical Society.



of vision, and indeed it is difficult to demonstrate that it ever does." Now, in looking over Dr. Webster's cases, I find not one in which the patient who used alcohol did not *smoke* to excess. On the other hand two who smoked to excess used so little alcohol that I think even Dr. Webster would not claim it had any share in the effect upon sight, proving, so far as Dr. Webster's cases are concerned, that tobacco alone may impair sight, and that in no case was alcohol the only or even the chief factor in the causation of the amblyopia.

*E. g.* Case 7, C. McK—, æt. 49. Has smoked 10-15 strong cigars daily for ten years; *occasionally* drinks a glass or two of gin. Vision =  $\frac{1}{16}$  each eye. Incipient atrophy of optic nerves.

Case 12, æt. 60. Sight failing over a year. Has smoked a strong pipe most of his waking hours for more than forty years. Has *rarely* tasted liquor. Vision equals  $\frac{1}{40}$  each eye. Brick dust atrophy of both optic nerves. Ordered to stop tobacco, and return in a week. *Then* vision in right eye *doubled*, in left eye all but doubled.

McKenzie, one of the worthy fathers of ophthalmology, originally pointed out the effects of tobacco. In 1840 he wrote, "I have already had occasion repeatedly to hint my suspicion that one of the narcotico-acrids, which custom has foolishly introduced into common use, namely tobacco, is a frequent cause of amaurosis." In that pre-ophthalmoscopic day, amaurosis meant obscurity of vision, depending upon a supposed morbid condition of the retina or optic nerve (McKenzie). In the present day, the terms amaurosis and amblyopia give rise to great confusion, from their various application. It would perhaps be best to restrict the term amblyopia to all cases of impaired sight, and amaurosis to cases of absolute blindness, without ophthalmoscopic symptoms. More recently, Wordsworth, Critchett, Hutchinson, &c., have given great attention to the effects of tobacco upon the eye, and believe it gives rise to impaired sight and blindness, with or without ophthalmoscopic signs. Hutchinson, who is probably the best authority on tobacco amaurosis, wrote in 1867 as follows: "The first stage, one which is very transitory, and perhaps often altogether omitted, is one of congestion, during which the optic disc looks too red. Then follows pallor of the outer parts of the nerve disc. During these stages the patient complains of dimness of vision merely. In a later

stage the whole disc has become pale, even to blue milk whiteness, and later still there is advanced atrophy. The stages generally occupy from four months to a year. In many cases the patient becomes at length absolutely blind, but in others the disease having advanced to a certain point, is arrested. There is from first to last no evidence of any disease of any structure in the eyeball, excepting the optic nerve. Almost always both eyes are affected, and progress *pari passu*. Sleepiness, a little giddiness, and a little headache, are usually the only constitutional symptoms which attend it." Three-fourths of his cases recovered. In a personal interview with Mr. Hutchinson at Moorfield, in 1875, he remarked he had come to think the effect of alcohol antagonistic to tobacco, as a cause of amblyopia, unless the alcohol is taken in such excess as to produce degenerative or undermining effects on the constitution. He had seen amblyopia more frequently and more advanced in smokers who abstained from alcohol, than in those who took it. Dr. Berry also holds a similar opinion. He cites two cases of tobacco amblyopia; one a man of seventy, who had been a teetotaller for forty years, and the other a boy of 19, who did not drink. Berry, in common with many others, has remarked the symptoms often gradually disappear on the cessation of smoking, without any other treatment, and frequently without the supply of alcohol being diminished.

Since Hutchinson's description of tobacco amblyopia in '67, he, in common with many others, has examined more systematically the field of vision and color vision, and has found that the diminution in sight is confined to central or direct vision, while usually, eccentric vision remained relatively good, and they have found that color-blindness exists over a portion or the entire extent of the visual field. The color-blindness is for red or green, the red appearing blue, and the green appearing white, gray or yellow. The color-blindness in slight cases of amblyopia requires very careful examination to determine, as it is confined to the central part of the field, particularly within an area stretching from the optic nerve to the macula.

In 37 cases of atrophy of the optic nerve, Hutchinson attributed 30 to the effects of tobacco, and in 36 cases of optic nerve atrophy, Lebr found color-blindness an almost constant symptom, the



perception of color remaining intact in only three. Berry says he has looked out for the symptoms of tobacco amblyopia in women for the last five or six years, and has only met with them in three cases. These three women smoked to excess, but did not drink. Forster cites 20 cases, in a paper on the injurious action of tobacco on vision, each one of the patients being a strong smoker, and only able to see very large type. In 11 of these cases marked improvement was observed when the use of tobacco was given up. I will not detain you by quoting the language in the text-books on diseases of the eye at my command, by authors who express their full belief in tobacco amblyopia and amaurosis, simply stating they are English, Scotch, American, German and French, and among the best authorities. The authors are, McKenzie, Wolfe, Gowers, Wells, Nettleship, Noyes, Williamson, Stellwag, Schweigger, Grunfeld, Mittendorf, Mayer, and De Wecker. The only two authors I have who dissent from the general view are Carter and Lawson, English. Carter quotes a letter from Dr. Dickson, of Constantinople, to the effect that the consumption of tobacco in that city averages 3 lbs. weight per head per month, but that amaurosis is a rare affection there. He quotes also Dr. Hubsch, oculist in Constantinople, who writes, "I have never attributed amaurosis to the abuse of tobacco." Carter adds, "I have obtained the same kind of negative evidence from Egypt and India, and in the face of it I do not attach much importance to the fact that several patients who have suffered from nerve atrophy, have been great smokers. If a patient who consults me on account of nerve atrophy is a smoker, I always advise him to lay aside tobacco. This would be dictated by the duty of leaving nothing undone, and would not represent any personal belief in the necessity of the prohibition." I cannot comprehend why Mr. Carter thinks it his duty to give advice in which he does not believe, unless he thinks the belief of others a stronger reason for his duty than his personal belief, in which case he must hold his own opinion very feebly. Mr. Lawson, one of the surgeons of Moorfield Eye Hospital, thus writes: "I do not remember ever having seen a case in which the loss of sight could be fairly attributed to tobacco only. There was also in addition to the immoderate smoking some other excess, such as intemperance, or undue mental strain with loss of rest."

In looking over my notes of 1824 eye patients who have consulted me since 1877, I find 46 who had partial to total loss of sight accompanied by conditions of the eye similar to those noticed in tobacco amblyopia, viz., either no ophthalmoscopic or otherwise detectable change of the eye, or else hyperæmia, pallor, or atrophy of the optic papilla. These 46 cases may be thus classified: male 33, females 13 (46). Cases referred to smoking alone, 13; tobacco and alcohol, 9; alcohol alone, 0; other causes, 24. Tobacco and alcohol, males 9, females, 0; tobacco, males 13, females 0; other causes, males 10, females 14. Cases in which there was hyperæmia, pallor, or atrophy of the disc: tobacco, 12 male; alcohol and tobacco, 9 male; other causes, 7 male, 11 female. In regard to these figures I would remark that although no case of pure alcoholic amblyopia appears, it is because every one of the drinkers who consulted me was an excessive smoker, a rule, perhaps, with few exceptions, yet I believe amblyopia potatorum is an entity, as is very generally held in Paris. I must admit not having questioned females as to smoking and drinking, as they are so free from such male virtues. Again, in all the cases but one of tobacco or tobacco and alcohol, I noticed changes in the optic disc, as the patients did not consult me in an early stage, when ophthalmoscopic changes are not noticeable. I will briefly refer to four patients who did not take alcohol and had tobacco amblyopia:

J. T., æt. 44, consulted me in Feb. 83, complaining that his sight had been defective for eight months, and he was unable to see more than half a word at a time with either eye, seeing the half on nasal side. Vision is one half in left and one-third in right eye; outer half of each optic papilla pale. Patient has smoked six pipefuls daily for 15 years past. Advised to take strychnia and stop tobacco. Patient returned in two months, said he had followed advice and sight was all right.

H. O., æt. 21, Dec. 28, '83, said both eyes had gradually failed during the past 15 months, and now he can barely distinguish light. There is advanced atrophy of both optic discs. No symptoms of brain or spinal disease, no history of syphilis, health good. Has for four years past smoked 6-7 pipefuls daily, and chewed one-fifth lb. of tobacco weekly. *Treatment*—Strychnia, hypodermically, m. iv. ter die. (grs. iv., ad 3 i.

solution) and increase mj. daily; stop tobacco. Strychnia spasm was not felt till the dose reached m xxv, equal gr. one-fifth, and then only occasionally felt. Vision remained the same after one month's treatment. Feb. 4, '84.—R Strychnia, gr.  $\frac{1}{2}$  ter die, by stomach, and gradually increase the dose. Feb. 8th—Apply galvanic electricity to nape of neck and closed lids, three minutes daily to each eye. Feb. 27th—Taking strychnia gr.  $\frac{1}{2}$  ter die, by stomach, and feels spasm only occasionally. Vision, each eye increased to  $\frac{1}{10}$ . April 7th, '84.—Discharged with vision  $\frac{1}{10}$ , and able to see his way about well. Patient only diminished the amount of his smoking.

Nov. 25, '80—J. McK, æt. 31. Sight failing three months. Vision, right or left eye, =  $\frac{1}{17}$ . Has smoked since 11 years of age, and for three years past 10 pipes a day. Takes a glass or two of whiskey only once in months. Both papillæ hyperæmic. *Treatment*—Stop tobacco, cup temples, take iodide of potassium. Jan. 5, '81—Patient returned; stopped tobacco and gained 12 pounds in weight. Vision has increased from  $\frac{1}{17}$  to  $\frac{1}{3}$ . Outer half of discs now pale. Jan. 20th—White atrophic lines on discs and along vessels, perivascular atrophy; vision the same. Prescribed strychnia.

Oct. 22, '79.—W. S., æt. 21, noticed nine months ago while in school he could not see to read with right eye, and six months ago noticed the same defect in the left, but two weeks later could see to read fairly well. A week later still the eye again failed. With right eye can count fingers at 6" on temporal side only. With left eye, vision is  $\frac{1}{41} = \frac{1}{16}$  (Jaeger). Fundus of eye normal, unless there is some engorgement of retinal veins. Patient is anæmic and nervous, but he considers his health pretty good. Has smoked 6-8 pipes a day, from the age of 15, until two years ago, and 3-4 pipes daily since. Diagnosis, tobacco amblyopia. Prescribed strychnia. Discharged after nine days' treatment, with vision of right eye increased 8 times, and doubled in left eye. Continue strychnia by stomach.

Finally, gentlemen, I am prepared to hear you maintain that impaired sight, the use of tobacco, and the wearing of leather boots, for instance, are coincidences, only that and nothing more. The only additional argument in favor of tobacco amblyopia I shall detain you with is, that the quality

of the tobacco and the mode of smoking in Turkey differ so much from the "shag" of England, and the mode of smoking in England and America, as possibly to account for the absence of tobacco amblyopia in Constantinople. Sir Henry Thompson says the ladies of Constantinople smoke fifty cigarettes a day, merely taking a few whiffs from each, and then throwing the cigarette away, and he considers little harm ensues from such smoking. To deny that tobacco produces amblyopia, because a large number of smokers escape, is as rational as to deny that small-pox can reproduce itself, because a large number of the exposed may escape the disease, or to deny that cold or wet can produce rheumatism, because so few of the exposed suffer.

## ON TRACHELORRHAPHY—WITH CASES.\*

BY DR. SKENE KEITH, EDINBURGH.

(Reported by Dr. H. Aubrey Husband.)

The operation for restoring a torn cervix uteri is not yet generally recognised in the southern part of this country, and some of the so-called Emmet's operations would greatly astonish the great American apostle of clipping and stitching. The few cases he had to relate brought out forcibly the necessity for following up the after history of the patients. He had heard of several cases who were no better some months after the operation, and who were supposed by the operator to have been cured, for example, he knew of a lady who a few months after the operation was no better but rather worse, as she was suffering from constant bloody discharge in addition to her other troubles. This discharge was accounted for by the presence of a wire suture in one lip and want of improvement by complete failure of union, yet it may have been put down as a cure as the patient did not see the operator after the first few weeks.

CASE I.—Mrs. G. had suffered for fifteen years from pain in both groins and from a constant aching in the region of the sacrum since the birth of her only child. The labor had been a natural one. After years of treatment she at last saw Prof. Skene, of Brooklyn, and was advised by him to have the cervix uteri repaired. The cervix was torn on both sides of the os, almost to the vagina,

\* Read before the Obstetrical Society of Edinburgh, July 9, 1884.

and there was some, although not very marked, rolling out of the lips. The uterus was of normal size, and was not displaced. Dr. Skene allowed me to perform the operation and assisted me on the 21st December, 1881. Sims' speculum was used to bring the cervix into view in this and the other operations. After passing a sound I fixed on each lip of the cervix a double tenaculum at the spot where the centre of the external os was to be. With Skene's hawk-bill and Emmet's scissors I pared first the left and then the right side of the cervix leaving the central part untouched for the cervical canal. There was little hemorrhage. Three sutures were required on each side and after they had been tied up I passed a sound to be quite sure that the cervical canal was patent. This precaution is not altogether unnecessary, for I have since seen a cervix on which a so-called Emmet's operation had been performed, but where the menstrual discharges after the operation escaped through a small opening at the junction of the cervix with the vagina. There was retention of urine for twenty-four hours, and this was the only trouble the patient had after the operation. The sutures were removed on the seventh day, she sat up on the tenth, and at the end of a fortnight she came to Dr. Skene's office. The union was not as good as it might have been. However, the backache was quite gone, and the pain in the loins was not so bad. I have not heard of her since.

**CASE II.**—A lady, age 26, was seen by my father in April, 1882. Two years before she had been delivered of a seven month child with forceps, after having been in labor with convulsions for 48 hours. Since then she has suffered from constant backache and leucorrhœa. On examination with the speculum it was seen that the left side of the cervix was torn, and that the tear extended into the mucous membrane of the vagina. The right side was intact. The cavity of the uterus was increased to four inches, and there was no displacement. In May, 1882, I operated in the same way as in the previous case, except that one side only had to be repaired, and that two of the eight silk sutures which were required were entirely in the vaginal wall. After the stitches had been tied the tear measured two and a half inches. The patient had no trouble after the operation. On the ninth day two of the sutures about the centre of the line were found to have cut their way out. Injections

of hot water were given night and morning, and the other silk sutures were left in for two days more. Three weeks after the operation the cervix looked almost as though there had never been anything the matter with it. The uterus now measured two and a half inches. The backache and leucorrhœa had entirely disappeared. This lady kept perfectly well for seventeen months. She was then delivered of a child at term and since has had a slight return of the old trouble. A short time ago my father found that there was a slight tear anterior to the former one.

**CASE III.**—The patient, age 29, came under notice in March, 1882. She had at that time been suffering for four and a half years, since the birth of her only child, from backache and pain in the left groin. The labor had been a natural one. The backache has steadily increased, and more especially during the last twelve months. The cervix was hard, torn on the left side only. In July I operated. On account of the hardness and hypertrophy of the cervix I had to remove a thick slice of tissue before I was able to turn in the everted edges. The bleeding was rather free at first, but had quite ceased before I introduced the five sutures which were necessary to bring the parts nicely into position. The sutures were taken out on the ninth day, and on the eighteenth the patient went home. The line of union was very good, the backache was gone, and the pain in the left side was somewhat better. In December of same year the patient wrote to say that she had no pain and was cured. She kept well until six months ago, the leucorrhœa appeared accompanied with occasional pain in the side and back. Her doctor told her that she was much better for having had the operation done, so I suppose that the present illness is not due to my opening up of the cicatrix.

**CASE IV.**—Mrs. H., age 31, suffered from backache, pain in the groin, and leucorrhœa for ten months, since an abortion at about the fourth month. She had been a patient of Mr. Butler Smythe at the Grosvenor Hospital for Women and Children, Westminster, for a number of weeks, and had improved to a certain point, but could not be made to advance further by any of the usual treatment for such cases. When Mr. Smythe asked me to look at the case the cervix was torn on both sides, principally on the left, and the everted edges

were covered by exuberant granulations which bled easily. The uterine cavity measured two and a half inches, and the sound passed backwards with a slight curve. Mr. Smythe asked me to operate and I did so in April, 1883. There was no special difficulty in the operation. I was able to raw the right side with one snip of the hawk bill scissors, as the tear on that side was small and required but one suture; three were put in on the left. Patient suffered from no pain or disturbance after the operation. When she left the hospital the cervix looked beautiful. The leucorrhœa was quite stopped, the backache somewhat better, and the pain in the groin as bad as ever. Now she is perfectly well.

CASE V.—Mrs. M., age 36, has not felt well for years, and since the birth of her last child, seventeen months before I saw her, had suffered from constant backache and leucorrhœa, and frequently from facial neuralgia. On examination, the perineum was found to be partially torn, and what was left of it was lax and soft. There was a considerable rectocele, and this caused great straining at stool. The cervix was low down, large, hard, torn, and the lips were much everted, the posterior being fully twice as thick as the anterior. The uterus was slightly retroverted and the cavity measured three inches. In May, 1883, I pared and brought together the everted lips. There was some difficulty in doing this on account of the difference in the thickness. Six sutures in all were put in. At the same sitting I cured the rectocele by repairing the perineum. Five weeks after the operation the cervix could not have looked better. The patient went to the seaside, and although she came back looking very anæmic and not fully well, there had been no leucorrhœa or face-ache, and the back did not pain her as much as formerly. In December the backache began to get worse, and I found that my patient had become pregnant, and about one-third of the cicatrix in the cervix had given way. She aborted, and I again pared and brought together the everted edges, this time with wire. A week ago the patient wrote to say that she was feeling much better.

CASE VI.—Mrs. L., age 21, was well until after the birth of her second child, four years ago. After getting up she suffered from bearing-down pains, which were relieved by wearing a pessary. Six months ago she was delivered of a boy-baby,

with forceps, and remained in bed for five weeks. Since then she has suffered from constant backache and pain in the left groin, and she has a profuse yellow discharge. When I saw the patient last November, the uterus lay low in the pelvis. The cervix was deeply torn on both sides, and there was a great deal of rolling out of the lips. The vagina contained a large amount of glairy mucus. After two months' treatment as an out-patient, during which time the cervix decreased in size the leucorrhœa got less. I thought that the tear would not improve further as it was an irregular one and I therefore operated. On the ninth day the patient felt perfectly well and had no pain. She went home at the end of three weeks, nursed her two children with measles, and her husband, who was also ill, and felt perfectly well for three months. Since then she had profuse discharge with pain in the stomach, and I have heard from Mr. Malcolm, who has been at the Samaritan Free Hospital, that there is considerable suppuration along the lines of the cicatrix on the right side, though the deeper parts appear to be quite firm.

REMARKS.—The operation of Emmet, when properly performed, is certainly of benefit in suitable cases, but I do not believe that it ought to be a very common one, for there are few women who have had a child without having their cervix uteri more or less injured, and most of these injuries do little harm. In my notes of a year's out-patient practice in the Samaritan Free Hospital, I found that I have marked down that there was a well-marked cervical tear in forty-two cases, yet in five only did I recommend operation and two of these five were on account of induration due to excessive application of caustics. Careful application of a mixture of carbolic acid and tincture of iodine with the hot douche and support of the uterus when necessary was found quite sufficient to heal up the other cases. Even in the Women's Hospital, New York, Emmet's operation is not a very common one. In four and a half months of the winter of 1881-2 I saw it performed there 24 times, and I was present at all the operations during that time. Trachelorrhaphy is not a very easy operation, at least, in most of the necessary cases, for in those the tissues of the cervix are much harder than natural. Where it is safe to draw the cervix entirely outside the vulva there would be little difficulty, but as this cannot be done I have found

that the most easy position is to have the cervix at its natural place at the upper part of the vagina, provided always that the patient is placed well in Sims' position and that the speculum is well held. There is far more room here than at any other part of the vagina. In forty cases I have but once seen hemorrhage of any intensity. In the others it either stopped before the stitches were introduced or after they had been brought together. I don't think that it is of importance what kind of sutures are used. In my next case I shall probably use wire for the crown ones, and silk, prepared according to Dr. Skene's method, for the uterus. The needles are of much greater importance. Dr. Emmet used round ones, but I don't find there is any objection to lancet-pointed needles, and certainly they go in much more easily. It is certainly a great comfort to fix into each lip a tenaculum of some sort, then one gets greater command over the cervix, and can keep it steadier than if a loop of thread or any other means be used.

Dr. Wilson congratulated Dr. Keith on his paper, and remarked that, considering the number of cases operated on the other side of the Atlantic, the midwifery must be somewhat rougher there than on this side.

Dr. Berry Hart did not understand the pathology of the cases operated on, and believed that some forms of inflammatory action went on in the parts. He would like to know the conditions Dr. Keith had met with in split cervix. He had seen pelvic cellulitis and other affections following the operation, and had heard many patients complain that they had not been benefited by the operation.

Dr. Milne Chapman had performed the operation with unfavorable results in four cases. He held that the tendency of Nature to heal the rupture in the cervix caused congestion of the part; this leads to a proliferation of epithelium, which prevented healing. In the one successful case a notable result was the diminution in sub-involuted uterus.

Dr. Barbour had seen eight or ten cases; the benefit derived was only in about one-half of the cases. He, however, held that Emmet's operation was based on sound pathology.

Dr. Arnot (Bombay) thanked Dr. Keith for his paper, and was glad to hear a new operation discussed. He held that the proof of the success of the operation depended not so much upon a good

cicatrix, but on the results of a year's experience. How much of the temporary success of the operation depends on the local hemorrhage, relieving congestion, the rest in bed, etc., which accompanied the operation?

Dr. P. A. Young had had no experience of the operation. The operation, he held, received the almost universal assent of the profession. He related a case of chronic split cervix, which was cured by Emmet's operation.

Dr. Brewis recorded five cases treated by Dr. Angus Macdonald, four of which were successful. In the unsuccessful case there was shortening of the broad ligament, which prevented the cervix being drawn down, as was the custom with Dr. Macdonald. There was also some ovaritis. The case at first did well, but on the removal of the sutures it was found that the rent had not been improved. In two cases he had seen severe hemorrhage; he had used a styptic composed of iron, alum, and glycerine, but found the vagina charred, due to the styptic used. This should only be used in hemorrhage due to malignant disease. All cases should be watched by the nurse, as severe hemorrhage may come on in any case.

Dr. Webster mentioned a case in his practice where a severe split cervix had been cured by hot water.

Dr. Keith replied that he once held that the operation should be done far more frequently, but he had since modified that opinion. As to the pathology he had formulated no theory. He had operated more because he thought the cervix was at fault. He thought that the operation, as a rule, should not be done in cases of pelvic cellulitis. Dr. Emmet said that the pelvic cellulitis should be first carefully treated, and then the operation might be carefully done.

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### THOMSEN'S DISEASE.

TRANSLATION BY J. WORKMAN, M.D., TORONTO.

This is a muscular affection, which has been brought into notice by several German physicians and one or two French within the last few years. It has taken its name from the gentleman who, having himself been the subject of it, in common with a large number of his family stock, throughout five generations, was the first to treat of it with

clearness and precision. No less than thirty-five members of the Thomsen kin were known to have been affected with the disorder. Of thirteen children of his mother, seven were found to present it. Hereditary transmission would therefore seem to underlie this morbid form, and it is by no means improbable that it has not been exclusively confined to Germany and France, though, from its rarity and its apparent triviality, it may have failed to attract particular attention. The writer of this notice believes that he has seen, at least, one distinctly marked case in Canada, within the last two years, and it may be that the perusal of the following notice of an article by Longuet, in a *Revue critique*, in the *Gazette of Military Sanitation*, will lead some of the readers of the LANCET to recall some observances, which at the time of their occurrence wore an anomalous aspect.

The notice above-mentioned is presented in the *Revista Médico-Quirúrgica* of Buenos Aires, for May, 1884, of which the following is a translation from the Spanish.

THE DISEASE OF THOMSEN.—In the critical review by Longuet, we have found the following historic details respecting the disease of Thomsen. The subject observed by Leyden was a discharged soldier, who was unable to open his fist when he had shut it; when reading, he was often unable to follow out the lines; the movements of his tongue were impeded; he could not dance or run. In the same year, 1876, Thomsen and Seeligmüller published the first two memoirs on the subject, which were remarkable for their clear and precise conception of the disease. Thomsen, who was not only an observer of the infirmity, but also a sufferer under it, and furnished the first description of it, has given origin to the name by which it is commonly designated in Germany. His own family presented several examples of it, coming down through five generations, in various degrees, and all presenting some form or other of neurotic character. Of thirteen of his mother's children, seven were affected with it. His own children also were affected, though in a mitigated form.

The case recorded by Seeligmüller was that of a recruit, who was a desperation to his drill instructors, because of the slowness and sluggishness of his motions, in spite of his own earnest desire, in the execution of the orders given him. At a later date, Peters, a surgeon major, published his obser-

vations of a soldier, 20 years old, who was affected similarly. At the command, "march," he remained immovable, as if rooted to the ground; afterwards, having moved his arms and legs disordinately, he succeeded in starting, but he vacillated for ten or twelve paces before he could attain free movement. He was absolutely unable to run, and if he persisted in the attempt he fell; his tongue and the maxillary muscles shared in the impotency; he could not raise his arms above the horizontal direction.

Westphal presented to the Medical Society of Berlin two patients, one of whom was a student of medicine and a nephew of Thomsen; he had been affected from his infancy. The symptoms are always the same; the functional anomaly may be presented in any of the muscles of the body. One of Westphal's cases showed that after sneezing, the patient could not again open his eyes without great effort, and when eating he could not always shut his mouth when he desired. The subjects of the affection have an athletic appearance, but their muscular force is only moderate. Westphal thinks there is a special congenital muscular perversion, coupled with an exaggerated muscular development.

Another recruit has recently attracted the attention of the assistant surgeon major Schonfield. This soldier was sent to hospital because, in his exercise, he suddenly fell to the ground, without any apparent cause. After a rest of ten minutes it was impossible for him to resume the march, at the word of command. He moved with great difficulty, and tottered and fell, rising again only with much difficulty. He had to proceed ten or twelve paces before he could move freely. When he sat down for any time, he could hardly rise again; the torpor, at such times, invaded the upper limbs, as the result of violent exercise. The speech was slow and drawling.

Mobins is the latest writer on the subject. He has published in *Schmidt's Jahrbücher* a very complete analytic review, having personally observed a young student of theology, who was a military volunteer, sent in by surgeon major Sane, who appeared to regard the case as a mimic form of the affection. This youth, after severe fatigue, suddenly became subject to cramps in the calves of his legs, and a stiffness of his limbs which left him powerless for many days. His father presented

the same defects, which were exasperated by the fatigues of military service. After a march, all his movements continued difficult for one or two days. Sometimes the loins were invaded, and after musket exercise, his arms, previously free from the trouble, became affected. The contracture is accompanied by a sensation of tumescence in the muscles attacked; but at other times by a sort of trepidation, like that from faradization; if the leg be extended, the whole limb enters into contracture, and remains for a time unable to bend.

A youth of 22, observed by Berger, presented in his exercise a torpor and rigidity which distracted his drill instructors. The French productions on this subject consist merely of the memoir by Ballet and Mare, published under the inspection of Charcot, and supplemented by a recent article of Mare's, who has given the following details of a case under his own observance. The subject, from early age, found that he had special difficulty in making any movement; when he was in class and was ordered to retire, he could not rise. When called into the army, he exhibited, under examination by the council of revision, the infirmity under which he labored; but the military surgeons did not believe in it; he was however set aside for two years, as of feeble constitution, at the close of which he was admitted. When he went to exercise, it was impossible for him to keep step with his comrades, and he had the like difficulty in managing his arms, as in attempting the motions he was seized with his contractures. The surgeon of his regiment declined to admit him as a patient, and he ordered him to the gymnasium to *soften him down*; but in these exercises also he was attacked with the cramps, and when, for example, he went to mount the wooden horse, he was seized in the moment of the effort, with muscular contracture, and he fell violently against the horse. There is no painful feeling in the muscular contraction.

It is not easy to account for this rare and curious infirmity. Does it consist in a lesion of the medulla, situate perhaps in the lateral cords, or is it a simple functional anomaly of the medullary apparatus? Should the affection be localized in the periphery of the nervous system, or in the muscles? All of these have been hypotheses advanced by different authors, but none of them appear satisfactory. Be it as it may, we have deemed it useful to call the attention of our colleagues to a

pathological curiosity which they may perhaps have opportunity to observe. It is well that we should know that a form of nervous disease exists, which consists in *initial transitory muscular spasm, probably hereditary, incurable and independent of any appreciable lesion of the nervous or muscular systems*. Such is the Disease of Thomsen, a designation now accepted both in France and elsewhere.—*La Gaceta de Sanidad Militar*.

## THE MODERN OPERATION FOR CATARACT EXTRACTION, WITH CASES.

BY W. TOBIN, F.R.C.S.I., HALIFAX, N. S.

(Read before the Nova Scotia Medical Society).

GENTLEMEN,—I propose bringing before this meeting the notes of some cases of cataract extraction, performed by myself, during the past two years, preceded by a description of the operation.

This operation, in each case, was what is known as the "combined modified linear extraction." It bids fair to become the favorite one with both English and continental surgeons. It consists essentially in an incision confined to corneal tissue, generally made upwards, combined with an iridectomy preceding the opening of the capsule. The instruments required are: a stop speculum—I prefer the one known as the Birmingham pattern,—a fixation forceps, one with a sliding catch being the best—De Wecker's; one of Graefe's narrow bladed knives, about five millimetres in breadth; an iridectomy forceps and scissors and a pricker, to divide the capsule. We may add a hard rubber spatula, also De Wecker's invention, to free the wound from tags of entangled iris or capsule.

The patient's eyes should have been examined, under atropine, some days previous to operation, if possible, and the nature of the cataract and its consistency ascertained; also the condition of the retina as to perception of light. The tension should also be noted and any history of previous inflammatory disease or errors of refraction. The eyelids should be freed, by appropriate treatment, from any pus-producing affection, such as Blepharitis (a frequent cause of flap infection). The steps of the operation are as follows: The patient is placed upon a bed or table with the head slightly raised. An assistant is required to administer chloroform—if an anæsthetic be given it is not



necessary—also to control the patient and to help with the iridectomy. The patient's lids and neighboring parts should be first washed with a disinfecting lotion. The operator's hands and his assistant's, the instruments and the water used, should also be rendered aseptic. It is advisable not to use sponges. A piece of absorbent cotton wool, moistened with boracic acid lotion, which may be discarded when soiled, answers every purpose.

The patient being fully under chloroform, we insert the speculum between the lids and secure it, Seizing a portion of the conjunctiva with our forceps, just below the vertical meridian of the cornea, we draw the globe downwards, and, entering the knife exactly at the sclero-corneal junction, at a point corresponding roughly to the upper margin of the pupil, we pass it slowly and steadily across the anterior chamber on a plane with the iris. Transfixing the opposite point, we carry the blade, with a sawing motion upwards and slightly forwards, making a flap whose summit should reach within a line or so of the corneal border. The assistant now takes the forceps whilst we seize a small portion of the iris and excise it. Resuming the fixation forceps, we pass in the pricker and divide the capsule, making a cross cut, which sometimes brings away a portion of it. Whilst we are doing so, and during the subsequent steps of the operation, the assistant raises and holds suspended over the globe the stop speculum. By pressing on the upper lip of the incision with the spatula and passing a similar instrument from below upwards along the cornea, we start the lens from its bed, and bring it into the lips of the wound, through which it is gently squeezed, perhaps losing some of its cortical matter in transit. The speculum is now withdrawn and the eye closed for a few minutes to allow the chamber to refill. By manipulating the upper lid over the globe surface, we collect the remaining cortical matter in the centre of the pupil, and, reopening the wound, by drawing the eye downwards, cause its escape in the gush of aqueous humor. It now only remains to free our incision from shreds of iris or capsule, with the spatula, to cleanse the globe and sulcus from clots, etc., and to apply the bandage.

I first place upon each eye a piece of lint soaked in boracic acid lotion, then fill up each orbit with layers of cotton wool and tie over all a Moorfield's bandage. This bandage is removed and the

dressings changed twelve hours after the operation, and is changed again twice a day for the first week. If all goes well it may then be discarded for a shade and protective glasses. I look at the operated eye (by oblique light, with a convex lens and a candle) on the second or third day. The patient is allowed to sit up after the first twenty-four hours; and to go out within the first ten days, should the weather permit it. The chief points in this operation as contrasted with the old flap extraction are: 1st, the antiseptic precautions; 2nd, the use of the narrow knife, which gives us great freedom in shaping our flap and allows us to correct a faulty incision even after penetrating the cornea; 3rd, by limiting our wound to the cornea, we get one which heals readily and we avoid a conjunctival flap, which by bleeding, etc., would interfere with the next steps of the operation; 4th, by doing an iridectomy, before opening the capsule, we free the iris from pressure during the escape of the lens, besides getting the undoubted prophylactic benefit of the operation—should we wish to be extra cautious the iridectomy may be done some weeks beforehand. 5th. The operation may be done without an anæsthetic—De Wecker never gives one, having once lost a patient under chloroform. The use of the spatula is also to be noted in cleansing the wound. Here eserine, as a pupil-contractor, may be also of service. Lastly I would draw your attention to our early examination of the wounded eye by non-irritating oblique light, and to the lessened confinement both to bed and to the house of our patient.

I enjoin a few cases illustrative of this method of operating.

CASE I.—Mrs. McC., aged 70, residence, Chester. Double senile cataract, complete in both eyes; a dyspeptic subject. Operated on right eye, assisted by Dr. Farrell. Made usual incision upwards. When about to extract the lens the patient showed signs of chloroform collapse. The operation had to be suspended till she was restored by artificial respiration and subcutaneous injections of brandy and ether. On recovery, the lens (hard, dark and small) came away easily. The eye was cleaned and the bandage adjusted. All went well till the sixth day, the patient then sitting up and using protective glasses. She incautiously removed them and a prolonged exposure to light brought on a sharp attack of iritis, with opacities



in the anterior chamber and vitreous. From this attack she made a tedious recovery. The treatment consisted in hot fomentations of belladonna and inunctions of mercurial ointment and belladonna extract with tonics and sedatives internally. However, in a month she was able to return home. The eye quieted down and the opacities were absorbed. Vision, which had been clear twelve hours after the operation, was restored, and she now sees fairly with the usual glasses.

CASE II.—Miss B., aged 55 years; residence, Halifax. Double senile cataract; complete in right eye, incomplete in left. An anterior synechia, the result of old iritis in the right. Operated upon the eye in Sept., 1883, assisted by Dr. Lawson. The usual corneal incision was made followed by a large iridectomy. The lens was found too large for the wound, which required a slight cut to free it. A portion of capsule adherent to the synechia obstructed the new pupil, but not seriously interfering with vision was allowed to remain. The bandages were removed within a week and recovery with good vision ensued without a bad eye symptom, though she suffered severely from rheumatism. She now sees well at a distance and can read with the usual glasses.

CASE III.—Mrs. C., aged 60; residence, Chester. Double senile cataract; mature in both eyes. Right some years, left one year. Can distinguish light from darkness. Operated on right eye 19th October, 1883, assisted by Surgeon-Major Orwin. Made the usual corneal incision, which in this case, however, was carried too far upwards, involving a conjunctival flap which bridged the incision (remaining uncut), bled freely, and obstructed the operation. In making the iridectomy the lens capsule was ruptured and the lens presented immediately. The conjunctival bridge was divided and the lens extracted; but from the incomplete division of the capsule this membrane had not retracted and occluded the pupil. An attempt was made to extract it with the forceps, but in doing so the posterior capsule was wounded, and there ensued a loss of vitreous. The wound was at once closed, and the eye was tied up with a compressive bandage. This was left unchanged for 48 hours up to which time there was no pain or uneasiness. The wound was then found healed and retained the aqueous. Pain followed, however, the reapplication of the bandage, and decided

iritis followed before the fifth day, shown by contracted pupil, haziness of anterior chamber, dimness of vision and pain over eyebrow. The iritis was treated in the usual way, by atropine instillations, hot fomentations of belladonna and mercurial inunctions, tonics and sedatives internally. In spite of all treatment, however, the pupil became contracted and updrawn, and when she left town, some six weeks afterwards, the eye was still irritable and vision was reduced to the counting of fingers. I have seen her quite lately (six months after the operation). The eye is quiet, the pupil V shaped and updrawn, but part of it is clear of capsule. She can find her way about the house, sees fairly at distance, and with glasses can read the large print of a newspaper. This case shows the troubles which follow a conjunctival flap. It also shows that it is better to leave the capsule behind, trusting to a secondary operation to clear it, rather than risk a loss of vitreous, by trying, injudiciously, to remove it.

CASE IV.—Mr. G., aged 62. Double senile cataract; mature in both eyes. A free liver who had suffered in his time from malaria. Operated on left eye on 21st April, 1884, assisted by Dr. T. Almon. The usual combined operation was done under chloroform, and the lens came away easily, on the end of the pricker. He suffered severely from pain, with great conjunctival inflammation during the first week, which I was at a loss to account for, till I found him considerably the worse for liquor, when visiting him with Dr. Almon, the sixth day after the operation. The eye became acutely inflamed, with chemosis, contracted pupil and dimness of vision. He was treated with solutions of boracic acid and atropine instillations. Stimulants (which had been allowed in moderation from the beginning) were withheld altogether, and a week after he was up and seeing clearly. I had a visit from him to-day (6th July) to fit him with glasses. The pupil is clear, key-hole in shape, and admits of good vision. With + 8 D. he sees well at distance ( $V=23$  De Wecker's types), with + 14 D. he can read the smallest type in the text book.

CASE V.—Mr. D., aged 55; residence, Newfoundland. Double senile cataract; mature in both eyes, right eye one year, left 8 years. Operated on left on 4th June assisted by Dr. T. Almon. A small, low-placed corneal incision, such as that

recommended by Lubrech—done upwards and confined to the cornea. The lens on presenting was caught by upper section of wound. By pressing this down with the spatula it escaped easily. No other complication attended or followed the operation. On the 3rd day I examined the eye. The wound was healed and the cornea clear. On the 5th the bandages were removed, and a floating shade of black cloth replaced them. On the 8th he was allowed protective glasses and was able to leave the house, with the eye well guarded from light and dust, to take exercise. At the end of the month I fitted him with glasses. With + 8 D. vision =  $\frac{2}{3}$  (reads De Wecker No. 7 at distance) with + 12 D. reads clearly newspaper type at 10 inches.

### Correspondence.

To the Editor of the CANADA LANCET.

SIR,—The following questions have occurred to me in an hour or two of leisure, and are submitted for consideration, not that they present any new features, for undoubtedly every physician in ordinary practice has mentally asked the same, but to show some prevalent faults and to draw attention to matters pertaining to the welfare of our profession. Besides, it was thought that they would be a departure from the ordinary and monotonous style of medical reading so constantly subjected to our notice.

I. Why are there so many physicians engaged in other employments outside of their profession, who delight in a semi-philanthropic practice to the discouragement of others who endeavor to excel in, and who live solely by their profession?

II. Why are there so many among us who, in consideration of their length of practice, seem to deem it an honor to subscribe to the virtues of "Domestic Medicines," "Every Man his own Doctor," "Household Physician," and similar works?

III. Why is it that now and then a physician in good health, and doing (as he says) a \$3,000 or \$4,000 a year practice, will accept a position which brings in one-half or less of the above?

IV. Why do some Physician-Druggists allow themselves to act as vendors of such remedies as "Sir Jas. Clarke's" and "Lady Huntingdon's"

female pills, which are directed to be used with caution (?) at certain times?

V. Why do ministers of the gospel whom we, as a rule, attend without any pecuniary reward, whenever occasion presents itself at the bedside of one of their flock, interfere with the instructions of the physician, or tell about some similar cases wherein different treatment was beneficially used?

VI. Why is it that among these same reverend gentlemen there exist some who, without admitting any medical knowledge or having pursued medical studies, insult the regular profession with announcements of some specific "croup and diphtheria" compound, life saving pill or compound?

VII. Who is to blame for the ignorance existing among the public in regard to the distinction between patent medicines and well established therapeutical preparations, and where is there a man outside of the fraternity or drug business who understands why we prescribe Syr. Hypophosph. Co. (Fellows) and not "Dandelion Blood Purifier"?

VIII. Do our young physicians go to Europe for extra degrees or extra knowledge?

IX. Are not our nauseous and muddy mixtures advancing the interests of Homeopathy and the patent medicine business?

X. Why as a rule do many of our town and village brethren keep such filthy offices, filthy bottles of all sizes, colors, and shapes (pickle bottles are not uncommonly noticeable), when they know that neatness, cleanliness and order pay well?

"An' then a' doctors' saws and whittles  
Of a' dimensions, shapes, an' mettles,  
A' kind of boxes, mugs, an' bottles  
He's sure to hae;  
Their Latin names as fast he rattles  
As A. B. C."

XI. Is there a physician of several years' practice who will deny the utility of a series of lectures to a graduating class pertaining to the ordinary duties and obligations of the profession to itself, and the public—and other minor details of a purely practical and business order, which so many of us have learned by sad experience and needless expense?

Yours, etc.,

QUEROR.

September 21st.

## Reports of Societies.

### HURON MEDICAL ASSOCIATION.

Oct. 7th, 1884.

Dr. Campbell, of Seaforth, presented a case of *empyæma*, in a boy 15 years of age, on which he had operated, first by aspiration, and after by free incision, removing, on the 29th May, six pints of sweet pus, and on the 12th June following, eight pints of foetid pus, by an incision three inches below the angle of the scapula. This was necessary on account of the distressing dyspnoea. Dr. C. was assisted by Dr. Elliott, of Brucefield. The treatment was, antiseptics locally, and syrup of the iodide of iron and Scott's emulsion constitutionally. Dr. C. also reported a case of puerperal eclampsia at eight months. Labor was induced, and delivery by forceps. The convulsions increased in frequency and violence until one-fourth of a grain of pilocarpine was injected hypodermically the second time, when recovery took place.

Drs. Gunn & Elliott presented a case of cirrhosis of the liver in a man 63 years of age. About two months ago he vomited nearly two quarts of blood and has not been well since. The question of cirrhosis was discussed, some thinking that it might be cancer of the stomach. The spleen, on percussion, appeared to be enlarged, and an incurable eczematous eruption covered his chest and face. Drs. G. and E. also showed a case of peculiar nervous hiccough connected with absence of menstruation, which has been in progress about four months, during three of which considerable vomiting was present. The hiccough is constant except when sleeping, and amounts to from 60 to 100 hiccoughs per minute.

Dr. Williams presented a case of blindness of both eyes from congestive amaurosis. The left eye became blind three years ago, and in the last week the other eye became blind in about three days.

Dr. Nichol, Bayfield, read a very interesting report of a case of traumatic tetanus, terminating fatally, produced by a gunshot wound of the thigh. The charge of shot had been in the wound three weeks when he first saw the patient, and tetanus had existed four days without treatment. The probe passed its whole length, and a counter opening was made to facilitate discharge. Any manipula-

tion of the wound at once produced a spasm. He died on the eighth day, twelve days after the tetanus began, and thirty-three days after the accident. Chloral hydrate appeared to be the only remedy that controlled the spasms. The question arose as to whether the charge of shot could not have been extracted and the young man's life saved. At the post mortem the charge was found a little beyond where the probe had reached, and a little perseverance in the early part of the difficulty might have found and extracted the shot by a counter incision.

Dr. Worthington, of Clinton, showed a case of compound fracture of the third metacarpal bone of the right hand, produced by a dull adze, the finger being shortened one-fourth of an inch. A method of extension was devised, and the wound was treated with boracic acid gauze. The wound united by first intention, and the patient suffered no pain from the first.

Some cases of ulceration of the leg were shown after typhoid fever, and a peculiar case of eczematous inflammation of the leg of long standing.

## Selected Articles.

### THE YEO RESPIRATOR.

Dr. S. Cohen, M.D., of Philadelphia, gives the following in the *Medical News*, Oct. 11th:—

Continuous inhalation of a volatile medicament by means of an apparatus worn over the nose and mouth—a so-called "*respirator*"—is by no means a novel idea; but the cost and clumsiness of most of the appliances devised for the purpose have until recently prevented this method of treatment from being carried out upon a sufficiently extended scale to afford a reliable test of its efficiency. Dr. I. Burney Yeo, of London, described and figured in the *British Medical Journal*, for July 1, 1882, a respirator constructed of perforated zinc bound with chamois skin, shaped to cover both nose and mouth, which carries a sponge upon which the medicament desired to be inhaled can be dropped, and which is retained in position by means of a pair of elastic loops passed around the ears. The lightness of this appliance, its cheapness, and its cleanliness, commend it as the best device for the purpose yet offered to the profession. Until within a few months it has been impossible to obtain the respirators in this country, and those used in the cases upon which this article is based, were imported. Messrs. Wyeth & Bro., of this city, are now manufacturing them, however, with a slight

change in style suggested by Dr. J. Solis Cohen. This modification consists in placing the sponge within a little cage formed by a fold of zinc in the front of the respirator, instead of retaining it in position by elastic bands.

The material of which the respirator is made being pliable, it can be accurately fitted to the face. The shape being adjusted, the sponge is wetted with hot or boiling water, and the medicament dropped upon it. The respirator is then fastened around the ears, and worn for such period as may be directed by the physician, or practicable for the patient. In many cases, the patient being engaged in his business occupations during the day, will consent to wear the respirator at night only. Some patients can sleep in them, others find it impossible to do so. The following are the substances



recommended by Dr. Yeo for inhalation; creasote, liquefied carbolic acid, spirits of turpentine, eucalyptus oil, terebene, spirits of camphor, solution of tar in rectified spirit, tincture of benzoin, and tincture of iodine. He uses of these five minims, either alone or mixed with an equal quantity of spirits of chloroform. Of course, any drug volatile at ordinary temperatures can be employed, but the list given by Dr. Yeo embraces nearly all which have been found of value in daily practice. I would add to it, however, chloroform, iodide of ethyl, and the alcoholic solutions of thymol and of menthol. Dr. Yeo's principal resort to treatment by the respirator has been in cases of phthisis, in which he has desired to keep up a continuous antiseptic inhalation; and the drug which he has found of the most service is creasote. From this treatment, in conjunction with proper hygienic measures and constitutional medication, he has obtained excellent results, some of which he has reported.

Dr. J. S. Cohen and myself have tested the method during the past two years at the German

Hospital, at the Philadelphia Polyclinic, and in private practice. The cases selected for this purpose number more than one hundred and fifty. While our results do not justify the endorsement of the plan as in any sense curative of phthisis, they have convinced us that much comfort may be afforded to patients past cure; that distressing symptoms may be quickly relieved, and in some instances entirely removed; and that recovery may be aided in cases affording reasonable basis for favorable prognosis. In other diseases of the respiratory organs, there has seemed to be a hastening of the favorable termination in some instances, and a marked degree of relief in others, even in chronic and incurable affections. Without detailing histories of cases the following general results may be recorded:

*In Phthisis.*—In cases with slight laryngeal involvement, the inhalation of terebene (ten drops, renewed every second or third hour) as continuously as possible during the day, with the addition of chloroform (five drops at bedtime) during the night, has seemed to allay the uncomfortable sensations of dryness and heat in the throat, and to restrain irritative cough. The relief has been particularly marked, and the gratitude of patients correspondingly great in cases in which, prior to the institution of treatment, sleep had been disturbed by violent spells of coughing two or three times during the night. In those cases in which the absence of a hemorrhagic tendency has permitted the use of daily inhalations of compressed air, after the increased coughing and expectoration caused by the loosening of retained and impacted secretions has subsided, there has been almost entire cessation of coughing. At most, in some instances, there has been a "clearing out" cough on arising in the morning, and in but one or two instances has an unproductive cough remained during the day or night. In dispensary practice, oil of turpentine (twenty drops) has been prescribed instead of the terebene, with almost equally satisfactory results. In some cases, however, especially those in which there has been organic lesion or functional disturbance of the kidneys, terebene and turpentine have caused distressing symptoms referred to the back of the head and to the ears, and apparently due to cerebral congestion. Many patients, even among those whose disease has already proved fatal, have declared that they could not be induced to part with "the little machine." In one case, which I shall at some future time report in full, the patient, a girl of eighteen years, complained that the dose of chloroform (three minims) ordered at bedtime, "smothered her." On increasing the dose to five minims, the unpleasant sensations disappeared, and she fell almost immediately, upon retiring, into a refreshing sleep, undisturbed by the cough that had formerly harassed her throughout the night. While it is only fair to add that in this

case there was a constant and remarkable improvement in every respect under constitutional treatment, yet the relief to cough preceded other favorable changes.

In cases with marked laryngeal disease, the amelioration produced by treatment with the respirator, while decided, has not been so great as in the preceding group of cases. These patients have, as a rule, done better under creasote than under terebene; and where there has been extensive ulceration, eucalyptol seems to have done more good than either of the other drugs. Eucalyptol, however, has been on the whole a very disappointing and unreliable drug, failing utterly in some instances, and as yet, without affording any positive indications as to the conditions in which it is likely to prove of service. Whatever drug has been employed in this group of cases, whether terebene, turpentine, thymol, creasote, or eucalyptol, the best results have been obtained from its admixture with chloroform or with spirits of chloroform; chloroform alone being used at night.

*In Bronchitis.*—In subacute and in chronic bronchitis, good results have been obtained from the use of the Yeo respirator, worn for an hour or two at a time, during the day and night, with terebene, spirits of turpentine, or tincture of benzoin, as the medicament. In bronchorrhœa and in fetid bronchitis, creasote and carbolic acid have been advantageously employed, either singly or in connection with one of the other remedies. Eucalyptol has been of value in a few cases. Ethyl iodide has given excellent results in cases of profuse bronchorrhœa. Even in a few instances of pulmonary gangrene, the fetor has been controlled by this drug, after failure of other remedies. In most instances, cough has been restrained and expectoration has been diminished in amount and corrected in character; while the subjective relief afforded has often been most gratifying.

*In Chronic Laryngitis and Tracheitis.*—In cases of chronic laryngitis in which burning or tickling sensations in the throat, or annoying cough, have constituted sources of distress, terebene, creasote, camphor, and tincture of benzoin have proved very useful. Eucalyptol has succeeded where the other remedies have not answered a good purpose; but has not been at all reliable. It must be used, if at all, in small quantity (two or three minims on the sponge at a time) or well diluted. The benefit of inhalation by means of the respirator has been most marked in cases of laryngo-tracheitis characterized by a constant desire to hawk out something that seems to stick in the upper part of the trachea; a purely subjective sensation. In these cases terebene has been chiefly used, but tar has also seemed to be beneficial.

## FIBROID TUMORS—DYSMENORRHEA—RAPID DILATATION.

CLINIC BY DR. GOODELL.

**GENTLEMEN:**—The first case is one which comes for diagnosis. The patient is a colored woman, 45 years of age, who has been married sixteen years, and had seven children, the youngest of which is five years old. She has not seen the menses for over one month. Previous to this they had been coming every two weeks, and were profuse. If she were an unmarried woman, or married and sterile, I should say that she either had a fibroid tumor or a polypus. But as she is a married woman and has children, then I would say, if she were white, that most likely she had carcinoma. On the other hand, she is a colored woman, and I have never yet seen carcinoma of the neck of the womb in a colored woman. We therefore come to the conclusion that she has some growth which causes the bleeding. The diagnosis lies between the rare disease of cancer and fibroid tumor. It is true that the bleeding might be due to fungous vegetations, but usually these do not cause bleeding every two weeks. They produce menorrhagia, with a profuse leucorrhœa between the periods. It might be a malignant growth within the cavity of the womb, but this is rare.

We shall now make the vaginal examination. The womb is decidedly larger than it should be, and on its posterior surface I feel a number of disseminated nodules. This is evidently a case of multiple fibroids. I had expected to find a tumor of some magnitude. The sound gives a measurement of 3.5 inches. I can feel the left ovary, which is hard, enlarged, roughened, and hardened. This is interstitial or parenchymatous degeneration, the result of ovaritis, and is not uncommon. I have never seen but one ovarian tumor in a colored woman, and that was in a mulatto. I can touch without much difficulty the promontory of the sacrum. She states that all the labors were hard, but that instruments were only used in the next to the last labor, and that all her children were very large. I can trace the sacrum all the way from the coccyx to the promontory. When you can touch the promontory of the sacrum with the finger, you may be sure that the pelvis is contracted. The promontory can be reached more readily in those cases in which the perineum is relaxed or torn. In this case the perineum is torn down to the sphincter.

Here is a woman whose womb measures three and a half inches, who has fibroid nodules in the posterior wall of the uterus, and also a laceration of the perineum. This latter, however, is not sufficient to demand the operation. She is not suffering enough to demand the operation. The change of life is coming on, and the nodules are not large

enough to warrant the idea that she is going to lose much blood. There has been an interval of a month since the last period, and perhaps the next may be longer than a month. We shall order for her ten grains of chloride of ammonium, and twenty drops of fluid extract of ergot three times a day. She will return in the course of a month, and report results.

The immunity of the colored race from cancer of the uterus is rather remarkable. Some of the southern physicians say that they have seen cancer in the colored race, but not so commonly as among the white race. They have another form of disease which the whites rarely have, that is keloid disease of the skin. I have seen this a number of times in colored people, but only once in the white race. Colored women are, however very subject to fibroid tumors of the uterus. It is rare to find a fibroid tumor in a white woman before the age of thirty-five years, but in sterile colored women from the age of twenty to thirty-five, they will be found quite frequently. These tumors do not cause death, although a physician who sees a great many of these cases has to operate occasionally. In a case which I saw the other day, I found a fibroid tumor as large as a man's head in an unmarried woman of thirty-nine. She is losing a great deal of blood, it is an anxious question to decide what is best to be done. Her physician states that during the past few months it has been growing rapidly. Now a fibroid tumor which increases rapidly in size may become so large as to interfere with any operation.

In operating for fibroid tumor of the uterus an exploratory incision is made, and if the tumor is found to have a pedicle, this is tied and the tumor removed and the wound closed, just as in the removal of an ovarian tumor; and this ought to be as successful an operation as removal of ovarian tumors. It is, however rare to find a fibroid tumor with a pedicle. They usually spring directly from the womb. When this is the case, the proper plan is to remove the ovaries, which is a simple operation. By so doing, not only is menstruation stopped, but large blood vessels passing to the uterus are ligated, and in this way the blood supply is to a great extent shut off from the tumor, and in the great majority of cases it will diminish greatly in size. I have performed the operation a number of times, and have failed to check the hemorrhage in only one instance, and in this case the tumor proved to be malignant. If the tumor is allowed to become too large, it may render the operation impossible. Two years ago I operated on an enormous fibroid tumor in a white woman of thirty. I had seen her a year previously and had urged the operation, but she preferred to wait. At the time of the operation the tumor filled the abdominal cavity, and must have weighed forty pounds. I had to make the incision from the ensiform cartil-

age to the symphysis in order to get the tumor out of the abdomen. The ovaries were attached to the tumor, and one of them was stretched to a length of six inches. It was a very serious operation, and the girl died in forty-eight hours. I have always regretted that I did not remove the womb in that case, although the result might have been the same. When the tumor is not large, it is possible to get at the ovaries without much difficulty. In these cases the ovaries and Fallopian tubes will as a rule, be found to be diseased. Very often the tubes are cystic. When the ovary is affected it is often a follicular degeneration in which the capsule is thickened and the follicles are enlarged and project from the surface, or else an interstitial degeneration in which the organ is enlarged, roughened, and hardened, cirrhotic in character.

#### DYSMENORRHOEA: RAPID DILATATION.

Here is a patient thirty-one years of age, married and sterile, who has had a great deal of pain since the time of puberty. This has been so bad as to incapacitate her for work, and it has been growing worse and worse. Why should she have pain, and why should it grow worse? If an unmarried woman, or a woman who is married and sterile, comes to you with a history of dysmenorrhœa, what should pass through your mind? That it is a dysmenorrhœa from ante flexion; that it is due to a stenosis caused by the womb bending too sharply towards the front—towards the front because she has never born children, and the natural position is slight ante flexion. This is an exaggerated condition. There are very few exceptions to this rule. Sometimes there is retro flexion. As a rule, you will find ante flexion. The dysmenorrhœa is mechanical, and usually gets worse after marriage. The woman may have been able to get along pretty comfortably before marriage, but afterwards the pain becomes worse and worse. Nature intended that when a woman got married she should become pregnant, and if a married woman does not have children, she nearly always suffers. The pain of dysmenorrhœa, due to stenosis, is usually of that character. It gradually becomes worse until it culminates, and when it reaches the highest point, there is a sudden gush and the pain subsides. Then it begins again and reaches another culmination, which is followed by a gush and relief. The womb is bent. The menstrual blood tries to overcome the bend, but it cannot do so until it has straightened the womb. After the womb is sufficiently distended to remove the bent condition of its neck, there is a sudden gush of fluid followed by relief. The same thing is seen when a rubber tube is bent; the water flows through the tube until it reaches the bent portion, when it is arrested until the force behind becomes sufficient to straighten the bend, and thus overcome the obstruction. The pain is due, not only to distension of the womb, but also

to the efforts of the organ to force the blood out of its cavity. This causes thickening of the endometrium, which in turn tends to increase the difficulty. When a woman suffering with this form of dysmenorrhœa gets married and does not bear children, the congestions arising from sexual intercourse will cause greater thickening and hypertrophy of the lining membrane of the womb, and consequently the cervical canal becomes still more contracted. There is not only thickening of the endometrium, but also hypertrophy of the parenchymatous structure of the womb. Then there is congestion of the ovaries and structural changes following on this congestion. These changes may either result in follicular or interstitial degeneration.

I shall now make a physical examination. The first thing I detect is a virginal cervix. It is not thicker than my little finger. The os is very small. With a little manipulation, I get the sound past the bend and obtain the measurement of three and a quarter inches. This increased length of the womb has been produced by the dysmenorrhœa. I propose to operate for this trouble by forcibly dilating the neck of the womb. The cutting operation is the one usually recommended in the books, but that is a dangerous operation, and is by no means as successful as forcible dilatation. I have notes of one hundred and fifty cases in which I have performed this operation, and there has not been one fatal result, and in but one or two has there been any pelvic inflammation. To show you the result of the operation, let me refer you to a case on which I operated a number of years ago. A clergyman's wife came to me suffering greatly with dysmenorrhœa. She had been married several years, and was sterile. I dilated the canal and heard no more of the case until a few days ago, when I saw her physician who told me that after the operation she had gone home, and the first year had twins and has been having children ever since. I have had a number of such cases, in which pregnancy followed the operation. In the majority of cases, it is not necessary to perform the operation more than once, provided it is done thoroughly under ether. Women often object to taking ether, and want me to do it in my office without ether. I always tell such patients that the operation gives a great deal of pain, has to be repeated frequently, and is very imperfectly performed under such circumstances. I tell them of the man who had a dog of which he was very fond. The dog had a long tail greatly disfiguring him. The tail had to be cut off, but the owner of the dog disliked to give the dog so much pain—he therefore concluded to take off an inch a day until a sufficient length had been removed.

I shall first take this Ellinger's dilator and tunnel my way into the womb. First, introducing the dilator as far as it will go and dilating to that point, then pushing it a little farther, I again dilate, and

in a few minutes the instrument passes the internal os. Sometimes when the os is too small to admit the entrance of the dilator, I enlarge it with the scissors, keeping the blades closed, and using them with a boring motion. As I remove the dilator, you observe that a quantity of thick mucous follows its withdrawal. Whenever this is seen it is an evidence of obstruction. I shall now introduce the larger Wilson's dilator. In buying a dilator of this kind, you should be sure to see that it has these little shoulders on the blades to prevent it from slipping too far into the uterus; for if the blades should come in contact with the fundus of the womb and be separated in that position, there would be risk of producing serious injury. After dilating up to a certain point, I wait a while. In all the cervixes that I have dilated, I have torn only two. One was in a virgin and produced a slight laceration. The other was in a case which had been treated by the application of nitrate of silver until the tissues had been made brittle by the formation of cicatricial tissue. In that case a slight laceration was produced, and the bleeding was free enough to require the application of Monsel's solution. That is the only case in which I found it necessary to apply any styptic. Sometimes I get hold of a very small cervix, one which is really infantile. Under such circumstances I do not expand the instrument to its fullest capacity, for fear that I may tear the cervix. In the majority of cases, however, I dilate to the fullest extent of the instrument. This gives an os through which the finger may be passed to examine the interior of the womb, and in many cases this is better than dilating with sponge tents. There is not the same danger as exists with sponge tents. On the other hand, tents will dilate to a greater extent. After a dilatation of this kind I can often introduce my finger into the womb, although I am not usually able to do so in sterile cases. I have now separated the blades of the dilator to their fullest extent. I shall remove the ether and allow the instrument to remain until the woman begins to flinch. Just before beginning the operation, I introduce a suppository of one grain of the aqueous extract of opium into the rectum, so that by the time the operation is completed the suppository will have dissolved and the opium be absorbed. At first the pain is great, but it soon subsides. Usually two suppositories are all that is required, one being given at the time of operating, the other two hours afterwards. If the pain continues, the opiate must be repeated. If there is much soreness, I have a poultice placed over the abdomen. I always like to keep these patients in bed for forty-eight hours. For the first twenty-four hours I order a light diet, and after that the patient returns to her ordinary food. If the soreness continues, I keep them in bed until it disappears. The woman is now beginning to show evidence of feeling the pain, and I



shall remove the dilator. It is very probable that some of the muscular fibres have been ruptured. I know that some of them have been over-stretched and will never contract as before. There is, as you see, a little oozing of blood, but I shall not attempt to check this, for I consider a little bleeding an advantage, as it tends to prevent the occurrence of inflammation. I have never had severe metritis or peritonitis after this operation. I have, however, seen slight localized inflammation follow it.

You will often be consulted by sterile women who want to have children. It is a mania with them. If a woman wants to have children, she will go through fire and water to become pregnant; and on the other, hand, if she does not want to have children, which I am sorry to say is the crying evil of the day, she will go through fire and water to prevent conception. If a woman wants children, all her friends know of it. Sometimes this operation will enable such a woman to become pregnant. At times, however, the condition has lasted so long that changes in the uterus have been induced which effectually prevent conception. If you are fortunate enough to enable her to have children, she will blazon your name and skill all over the neighborhood. If this operation is done carefully, I can recommend it most confidently. It is much safer and far more successful than the cutting operation, which I am happy to say is now rarely performed. —*Med. and Surg. Reporter.*

## WOUNDS OF THE INTESTINE—GROSS.

\* \* The diagnosis of wounds of the bowel is a matter of primary consideration, as upon its prompt determination the success of our treatment must mainly hinge. The possibility of this will, of course, mainly depend upon the situation in which the bowel is found at the time of the accident. If it has escaped through the wall of the abdomen it will generally be easy to find the injured part by the egress of some of its contents, as fæces, mucus, or bile, or all these together; and so also when there is a discharge of some, or all, of these substances through the outer wound, although there be no protrusion of the intestine. The coast in both of these conditions is sufficiently clear; so clear, indeed, that he who runs may read and accurately interpret. But it is altogether different when the abdomen has been pierced with a narrow instrument, as a knife or a dirk, or perforated by a bullet. In such an event the bowel does not protrude, and hence the true nature of the case must be solely a matter of conjecture. All that is positively certain in such event is that there is a wound in the wall of the abdomen. The surgeon, especially if called immediately or soon after the receipt of the injury, must be in doubt whether the weapon has entered the bowel or not. In reflect-

ing upon the subject he recalls the fact that a bullet, a rapier, a sword, or a ramrod has occasionally passed through the abdomen, and, perhaps, even emerged at the opposite side, without in the slightest degree interfering with any of its contents. The records of surgery furnish many such cases.

The two principal signs which must serve to guide us in these uncertain cases are tympanites and a discharge of blood by the anus. The occurrence of tympanites is unquestionably a symptom of great value. Jobert, who was the first to notice it, regards it as the most reliable of all the phenomena when there is no escape of fæces, mucus, bile, or other fluid at the abdominal wound, and in this opinion the results of my personal observation fully coincide. The tympanites supervenes at various periods; sometimes almost immediately after the wound in the bowel has been received, and is then always of proportionate diagnostic value; at other times it supervenes very gradually, and in some cases, again, it does not make its appearance under twenty-four, thirty, or thirty-six hours. However this may be, it is always diffused, not circumscribed, and sometimes reaches an enormous height, the belly emitting a hollow, drum-like sound on percussion, and is then always very painful.

Although tympanites is generally present in lesions of this kind, there are cases in which it is entirely absent; as, for example, when the wound in the bowel amounts to a mere puncture, in which the opening is effectually closed by the protrusion of the mucous membrane, thereby preventing all escape of gas into the peritoneal cavity.

A discharge of blood by the anus I regard as a very valuable symptom of the existence of a wound in the bowel. It is especially valuable when it makes its appearance within a short time after the infliction of the external wound, and when it continues, more or less abundantly, for some days afterwards. As the blood is always intermixed with the contents of the bowels, it seldom comes away in a pure state, but is generally of a dark color, and of a grumous consistence.

No useful conclusions can be deduced from the shock and the pain which attend lesions of this character, since both vary greatly in different cases and in different circumstances, some persons suffering very little, while others, owing to the peculiarities of their nervous endowments, experience extreme distress.

In regard to probing wounds of this kind, the universal sentiment of the profession is opposed to it, on the ground that, while it can do no good, it would often be productive of great harm, by disturbing the relation of parts, and thus endangering fæcal effusion. I do not think, however, that this rule should apply to the mural wound. Here a probe, properly used, might at least afford useful



information in regard to the direction and extent of the external injury.

In the treatment of wounds of the intestines two leading indications are scrupulously to be kept in view—the prevention of fecal effusion, and occurrence of peritonitis. To secure the first, the only safeguard is efficient suturing of the wound. A case, it is true, occasionally recovers without any precaution of this kind, but this is owing to good luck rather than to good treatment. The question here naturally arises, should all wounds of the bowel, however small, be sutured? Upon this subject there was certainly till recently, if indeed there is not still, some diversity of opinion. Dionis, Palfin, Heister, and Sabatier state that enterorrhaphy is unnecessary when the wound does not exceed the diameter of a goose-quill or a penknife; and views of a similar nature are to be found in other writers, as Sharp, Richerand, Boyer, and Jobert. On the other hand, there are surgeons who are opposed to the return of the bowel into the peritoneal cavity, however small the intestinal wound, without the employment of sutures, lest fecal extravasation should ensue. The great Benjamin Bell, of Edinburgh, writing near the close of the last century, holds, in the midst of the darkness that surrounded him, the following emphatic language: "However small a wound of the intestine may be, it ought always to be secured with ligature; for, although it is alleged by some that we should rather trust to nature for the cure of a small opening than to insert a ligature, to me it appears that the opinion is by no means well founded, inasmuch that I would not leave even the smallest opening, that could admit either feces or chyle to pass, without stitching it up. Much danger may ensue from omitting it, and the hazard of the patient cannot be increased by the practice being adopted." This advice of the sagacious Scotchman, so clearly and emphatically enunciated nearly a century ago, is now the universal practice in all cases of wounds of the bowel, however diminutive, based as it is upon the well-ascertained fact that enterorrhaphy, when properly performed, is a harmless operation as compared with the risk of fecal extravasation and the consequent certainty of peritonitis.

Judging from the results of my own observations, I have long been of the opinion that there are only two sutures that should ever be employed in sewing up a wounded bowel. These are the continued and interrupted, with the modifications of the latter by Lembert and Gély. As to Jobert's method, which consists in invaginating the ends of the bowel, when completely cut across, so as to place the two serous surfaces in immediate contact, to facilitate their prompt union, the operation is not only extremely difficult, but very liable, even if successful, to be followed by more or less contraction of the tube at the seat of the injury, thereby

interfering more or less seriously with the transmission of its contents.

The interrupted suture is, as a rule, preferable to the continued, in all wounds of the bowel, whatever their extent or direction, whether they embrace the entire calibre of the tube or only a limited portion, and whether they are circular, oblique, or longitudinal. The operation executed with a long, slender sewing-needle armed with a thin, but strong, well waxed silk thread, is comparatively simple, affords ample security against fecal effusion, and is never followed by injurious contraction of the tube. The sutures should be placed not more than one line and a half, or the eighth of an inch, apart, and the ends, tied in a double knot, should be cut off close, so that in time the sutures may find their way into the bowel and be discharged along with its contents. I deem it very important that each suture should be fully one line from the edge of the wound, and that the needle should be passed deeply through the wall of the bowel instead of embracing its entire thickness—an arrangement which would almost inevitably be followed by more or less puckering, and by the consequent retardation of the cure. The operation of uniting the bowel where the division is complete, will be greatly facilitated if the first suture be inserted at the mesentery and the second immediately opposite. The best, certainly the safest, ligature for suturing a wounded intestine is ordinary sewing silk, well waxed, and inserted with a long, sharp sewing-needle. The carbolized catgut ligature is liable to give way prematurely, and should, therefore, be avoided.

In the modification of this suture by Lembert, the object is to invert the edges of the wound so as to bring the two serous surfaces in immediate and firm contact, to establish, as it were, union by the first intention. Great advantage has been claimed for this form of suture, but this is not so apparent when it is remembered that, unless great care be taken in introducing it is liable to be followed by more or less contraction of the tube. In making this suture the needle makes two dips on each side of the wound instead of one, as in the ordinary procedure.

Gély's suture, which is merely a modification of that of Lembert's, is made with two needles inserted near the angle of the wound, about one line from its edge; they are then carried along the interior of the bowel, parallel with the wound, for the sixth of an inch, when they are brought out precisely at the same level, so as to appear again on the peritoneal surface. The threads are then crossed, the right needle being passed through the puncture made by the left, and conversely, when the ends are firmly tied and cut off close, as in the ordinary operation. The number of sutures varies, of course, according to the extent of the cut. In this way the edges of the wound are thoroughly in-

verted, and consequently all danger of fecal effusion is prevented: the coaptation, in fact, is so accurate as to conceal the ligatures.

The treatment of wounds of bowel by the continued suture has afforded good results in my experiments upon dogs. The chief objection to it is that it leaves the edges of the wound in an uneven, puckered condition, which interferes, perhaps, somewhat with rapid union. This, however, may be prevented in great degree, if not wholly, by the employment of a double thread, after the fashion of the glover, although I do not consider this at all essential to success. Of the seventeen experiments performed with a single ligature, not one terminated fatally. The wounds in two of the cases were transverse, oblique in three, and longitudinal in twelve. The wound in one of the latter was six inches in length. The dog, a large, old one, was killed on the twentieth day, when every trace of suture had disappeared, with the full restoration of the calibre of the tube. I must not omit to state that in all these experiments the sutures were passed through the fibrous tunic of the bowel, or, in other words, outside the mucous membrane. We have here, then, also a very valuable suture for sewing up wounds of the intestines, especially well adapted to the treatment of longitudinal and oblique wounds; not so well, I think, to the treatment of transverse ones as the interrupted.

The suturing of the wound having been completed, and any foreign substance that may be present removed, the bowel is restored to its natural situation, followed by the omentum, in the event of its prolapse. It is hardly necessary to say that the protruded structures should be treated in the most gentle manner; any wiping that may be required should be performed with the softest cloth, and all firmly adherent matter should be picked off with the forceps. Generally speaking, the best way of cleaning the parts is to make free use of the syringe, charged with warm water. The operation may be completed with a one to one thousand solution of corrosive sublimate. The return of the bowel will be materially facilitated by the use of a little olive oil. If any serious obstacle offer, it must be surmounted with the probe-pointed bistoury, or by puncture of the tube, if it depend upon the presence of gas. The wound in the wall of the abdomen should be closed in the same manner as in ovariectomy, the sutures being carried through the peritoneum so as to protect the parts effectually against hernial protrusion, a thing never to be lost sight of after such lesions.

The question arises here, What should be the conduct of the surgeon when the bowel is wounded, but not prolapsed, owing to the small size of the mural opening? I do not think I can answer this question better to-day than I did forty years ago, when we knew comparatively little of abdominal

surgery, and when the most visionary enthusiast could not have dreamed of half the triumphs that have since awaited it. The case in question is a supposititious one, and is thus stated: "A man, after having indulged in a hearty repast, receives a penetrating wound in the abdomen from the thrust of a dirk or knife; the bowel is pierced, or it may be, nearly divided, and there is a copious discharge of fecal matter, both externally and into the peritoneal cavity, as is evinced in the latter event by the excruciating pain, the gastric oppression, and the collapsed condition of the sufferer. Here the most prompt and decisive measures must be resorted to, or the person will perish from peritoneal inflammation, with as much certainty as if his skull had been fractured and a portion of his brain had been let out. It will not do for the surgeon to fold his arms, and look upon the scene as an idle and disinterested spectator. Far otherwise; he has a duty to perform, and that duty consists in dilating the external wound, if it be not already sufficiently large, in hooking up the injured bowel, and in closing the solution of continuity with the requisite number of stitches, at the same time that the effused matter is carefully removed with tepid water and a soft sponge. All wiping must, of course, be carefully avoided, as this would add much to the risk of peritonitis.

It is a rule with all educated surgeons to do the work which they are called upon to perform in as complete and thorough a manner as possible, and nowhere is this precept of greater importance than in the treatment of wounds of the intestines. A case recently reported by Professor O. K. Roberts, of Louisville, Ky., will aid me in illustrating my meaning. A man was cut in the abdomen with a pocket-knife; the wound was three inches long; the bowel protruded, and was pierced at two points, one opening being of the size of a common lead-pencil, the other of a pea. The knife in its passage had stripped off the serous membrane over a space of one inch by one quarter. There were two slits in the mesentery, each one inch in length; and the patient had lost much blood. The mural wound was closed by sutures which embraced only the skin and superficial fascia. None of the bleeding vessels had been secured, and active bleeding was still going on from three points in one of the wounds in the mesentery, the other being occupied by a clot. It was in this condition that the man was found by Dr. Roberts, shortly after his wounds had been dressed by another surgeon. Satisfied at a glance that the case had not been properly managed, Dr. Roberts reopened the mural wound, secured the bleeding vessel with carbolized catgut ligatures, stitched the opening in the gut more thoroughly, washed out the peritoneal cavity with hot carbolized water, and closed the abdominal wound with deep sutures, completing the dressing by inserting a drainage-tube in the lower angle of

the wound. Under this treatment, with proper subsequent care, the man made a rapid recovery. Had the dressing originally applied been allowed to remain, death would have been inevitable; either from hemorrhage, peritonitis, or peritonitis and septicæmia. The case affords a happy exemplification of hasty, careless, slovenly surgery, on the one hand, and of thoughtful, wide-awake, scientific surgery on the other.

The therapeutics after all such lesions is sufficiently simple. The great point is to prevent peritonitis, or to combat it, if it takes place. The posture should be such as to relax thoroughly the abdominal muscles. The bowels should be locked up with opium, to prevent peristaltic action, and nothing but iced water or pounded ice, aided, if there be much gastric distress, by a small allowance of dry champagne, should be permitted during the first three or four days. Oppression from gas should be relieved with injections of turpentine and asafoetida. Peritonitis should be met with leeching, followed by vesication with cantharidal collodion, and full doses of opium; venesection will be proper when the patient is young and robust. A laxative of castor oil, or of sulphate of magnesium, may be given at the end of five or six days, if there be marked suffering from tympanites. The urine should be drawn off during the first few days, with the catheter.

I have, thus far, said nothing of gunshot wounds of the intestines. Such wounds are generally of a very serious nature, and are, therefore, liable to be followed by the worst consequences. In the first place, they are nearly always concealed wounds, from the fact that there is no prolapse of the bowel; secondly, such wounds are commonly multiple, as in one of my own cases, in which there were as many as eight perforations—two in the ileum, two in the jejunum, two in the duodenum, and two in the arch of the colon; thirdly, there is always more or less copious effusion of fecal matter; fourthly, great shock, to say nothing of hemorrhage, which nearly always attends; and, lastly, most patients who survive the more immediate effects of such injuries are almost certain to succumb to peritonitis. The only rational treatment in such cases is to expose at once, or with the least possible delay, the peritoneal cavity, to stitch up, or excise, the wounded bowel, and, lastly, to clear away all extraneous matter. Excision of the tube is imperatively demanded when the wound is very large, severely contused, or very ragged. Nothing short of this would answer under such desperate circumstances; and even then no sensible surgeon would venture to pronounce a favourable prognosis.—

*Med. News.*

## INFANT DIGESTION.

In the July number of the "Archives of Pædiatrics," Dr. H. R. Bigelow, of Washington, says: "The question of infant growth is one of assimilation. Assimilation of food will depend upon the integrity of the digestive function. The digestive system of the new-born is not formulated at once, but develops in logical ratio with the expansion of other parts of the body. Its measure is the requirement necessitated by the elaboration of tissue. Tissue-growth is a slow process, demanding special nourishment, and varied at each advance in age. The necessities of the child, both chemical and physiological, are not those of the adult, because each is adjusted with great exactness to the immediate environment. The excess of non-nitrogenous matter, which is an essential to adult life, is pernicious to the well-being of the infant. Muscles, when at work, consume principally hydrocarbonaceous aliments, and not albumenoid substances. In the infant there is no muscular exertion, and hence it draws more largely for its development upon the nitrogenous substances than upon the hydrocarbons. At birth the alimentary tract is short, the cæcum being very small and the masticatory organs are absent. Bidder says that the ptyalin appears only with the cutting of the first tooth. Reasoning from analogy, it is not improbable that the pancreatic and intestinal ferments are also inoperative until about the eighth month. Nature is not a spendthrift, and she would not call into useless action any function not demanded by the necessities of her own handicraft. With the eruption of the teeth a new era begins. Mastication presupposes increased development. Increase of development calls for increase of nourishment, and increase with variety in nourishment sets up new digestive processes, in which the ptyalin and other ferments play an important part.

"The alimentary tract of the infant is exceedingly susceptible, so the nursing women have to be very careful in their diet. Now, if this tract is so impressionable as to feel any departure from a standard diet in the mother, how much more seriously will it suffer in the administration directly of unwholesome cow's milk—not unwholesome, perhaps, in the light of general use, but unwholesome for the limited infantile digestion. It may have an acid reaction, or it may have come from a cow in heat, or it may be tainted with certain vegetable substances obnoxious to the child. The natural food of the baby is its mother's milk.

"An intelligent study of human milk will lead up to a more just comprehension of the demands of infant digestion, and to a more perfect knowledge of a physician's duty in prescribing for such cases as are, unfortunately, deprived of the mother's breast. It would be a valueless encumbering of space, and an expenditure of time without profit,

PROF. PARVIN favors the employment of anæsthetics during the use of the forceps.

to cite one half the analyses that are matters of record. It best subserves the present purpose to view the main constituents of human milk in their relation to certain physiological principles. It is to be noticed first, that woman's milk has an *alkaline* reaction, which persists for an indefinite period, and a specific gravity of about 1.0317. It contains water largely in excess (89.20 in 100 parts) milk-sugar, nitrogenous matter, fat, and salines. The albumenoids will vary in different women so largely that we can not affirm that any analysis is infallible. A fair average percentage would probably be about 4.84. The milk-sugar (6.987) is much greater than in cow's milk (4.92). These figures are only approximately correct. No two samples yield the same results. This variability in the composition of women's milk, if not pathological, is a wise dispensation of nature to provide for the exigencies of each month of advancing age. Thus the function of the milk-sugar as a heat-producer is kept constantly in mind, while the absolute rate of nutrition may vary within wide limits, because the bodily heat must be preserved at all hazard. In fat, women's milk exceeds that of the cow, but falls far below it in albumenoids. The ash, or mineral constituent of milk, is chiefly concerned in metamorphosis. The basic phosphate of sodium is invariably found in the blood while the acid phosphate of potash is the chief constituent of the juice of the flesh. Phosphate of lime is intimately incorporated with the nitrogenous constituent principles. It is very generally admitted that the carbohydrates lead on to fat-production, through the co-operation of the nitrogenous and saline elements. Nitrogenous elements themselves, when in excess, may also serve as a source of fat. Nitrogenous matters do not, probably, undergo complete oxidation within the body; a portion of them is eliminated as urea. Fatty compounds are of higher value as force-producers, because they contain a quantity of hydrogen as well as of carbon free of oxidation. Pavy says that the value of nitrogenous compounds as force producers depends upon the amount of unoxidized oxidizable elementary matter they contain. In human milk the percentage of nitrogenous matter to carbohydrates is about 1.45. About one fourth part of its casein is coagulable by acid. The *alkaline reaction* is *highly valuable*, since it serves to convert the *casein* into *soluble albumenoids* and soluble carbohydrates, which are great heat-producers. Writing upon this subject, Kuss says: 'It is generally admitted (Moleschott, Voit) that an adult consumes 320 grammes of carbon and 21 grammes of nitrogen, or in other words, 130 grammes of albumenoid elements, and 488 grammes of hydrocarbons and fats (fats 84, hydrocarbons 404); it follows that, in this case, the normal proportion in a mixed diet, of nitrogenous to non-nitrogenous aliments, is 1 to 3.7, while in milk, as well as in the egg, the proportion is 1

to 3, or even 1 to 2; in other words, the quantity of albumenates (nitrogen) is much larger, and of hydrocarbons (carbon) much smaller. This fact may be easily explained by referring to the part played by the hydrocarbons in regard to the production of force—muscular force especially. The adult draws his forces from the combustion of non-nitrogenous substances, the albumenates scarcely serving for this purpose. On the other hand, when the organism is in course of development, the nitrogenous substances are indispensable to the growth of the different tissues. It is therefore easy to see how mistaken is the common practice of condemning children to a diet containing a large quantity of starch and scarcely any nitrogen.'

'Women's milk contains no starch. It may be conceded that, in the adult, the ptyalin may continue its action in the stomach; that particles of unconverted starch may be transformed by the pancreatic and intestinal juices. In the infant this rule cannot apply. The baby does not secrete ptyalin until the sixth or eighth month, *neither do the other juices, of pancreas and intestine, have any transforming power whatever before that period.* It is sheer ignorance to assert small particles of starch can do no harm, since they undergo transformation in the intestine, when the truth is that they not only act as irritants, but pass out of the bowels unchanged. The attenuant of woman's milk is an important factor, of which we have little absolute knowledge. It is chiefly in consideration of this point that *cow's milk can not ever be safely substituted for that of the mother.* Before it can be satisfactorily approximated to this great food of nature it must be radically transformed by some chemical process, which science has not yet developed. The addition of water to cow's milk will reduce the percentage of albumenoids into harmonious relationship with human milk, but it does not suffice to change the characteristics of the clot. To use starch as an attenuant is, of course, radically wrong.

'In view of these facts, it becomes a matter of the utmost interest to establish some definite principles of treatment, in cases where the mother is unable for any reason to nourish her child properly and sufficiently. There is no known process, chemical or mechanical, by which cow's milk alone can subserve this purpose. Up to six months of age, at least, the baby needs just those equivalents found within the mother's breasts—nothing more and nothing less. The compound must be *alkaline* in reaction; it must contain no *cane sugar* (because cane-sugar must be first converted into grape-sugar before it can be assimilated; cane-sugar is frequently subjected to a kind of acetous fermentation, producing excess of acids in the infant stomach so that bodily heat will diminish and disorders of respiration and circulation will follow), and no *starch*. It must be rich in heat-producers, although, as I have said before, the amount of albumenoids

may vary greatly. Position has something to do with digestion. In some bad cases it will be found that, if the infant be placed in the usual position of a nursing child in its mother's arms, it will assimilate its food, when artificially fed, much more readily. In the nursing child a by no means inconsiderable amount of heat is derived from the mother's body. An artificially fed infant is deprived of this, so that there should be some compensatory action in its food. There have been many attempts made to overcome this difficulty, and our journals have been full of discussions upon the matter. It may be said that no artificially prepared food that does not meet in all these requirements will be of permanent value in infantile therapeutics. What is needed is something rich in carbohydrates, with a proper admixture of albuminoids, salts, and moisture, free from starch and alkaline in reaction."

Dr. Bigelow gives notes of three cases of disease in infants, with disturbed digestion or assimilation, in which great benefit attended the use of Mellin's food. "I satisfied myself," he says, "by personal analysis of the constituents of the preparation, and found that it contained the principles which it seemed to me nature demanded, in exact combination, and more satisfactorily and more cheaply prepared than I could compound upon my own prescription."

## EPILEPSY TREATED WITH HYDROBROMATE OF CONIA.

BY R. NORRIS WOLFENDEN, B.A., M.B. CANTAB.

Being frequently disappointed in the action of potassium bromide in the treatment of epilepsy, I have lately been trying a remedy which I believe has not previously been used for this complaint. If the result is not quite so favorable as I might have expected, it is at any rate sufficiently good to warrant further trial, and I venture to place on record the notes of seven cases, in the hope that it may lead to further observations. We have all experienced the failure of potassium bromide until poured in in such quantity that often a condition of bromism is established. The unsightly blotches thus produced are a source of annoyance, especially to the better class of patients, to whom personal appearance is a matter of concern. The following is a summary of my notes.

CASE 1. A., girl, æt. eight: ill for two years, with epileptiform seizures consisting of sudden flexions of the fore-arm (right), and a momentary vacantness of look; latterly the attacks had become more severe, culminating in loss of consciousness. Hydrobromate of conia, in doses of half a grain three times a day, was prescribed. During the first week she had six slight "fits." The dose was

then increased to  $\frac{5}{8}$  of a grain, and during the succeeding week she had no attack. The medicine was continued for four weeks, during which time she had no fits at all, and slept better. The drug was then discontinued for some weeks, when she returned for further treatment. During its administration this patient complained of constant frontal headache.

CASE 2. B., male, æt. 22: suffered from true epileptic fits, with typical aura, convulsions, unconsciousness, and great headache afterwards. One and a half grains hydrobromate of conia was ordered twice a day; during the week, this patient had nine fits. One and five-eighths grains was given twice daily for a week. During this time the patient had four bad fits. He was now, at his own request, put under potassium bromide, 3 j doses, three times a day, which kept them under.

CASE 3. C., female, æt. 34: had been ill for four years, with one or more fits every week, typically epileptic. While taking potassium bromide they were kept under. I ordered one grain of hydrobromate of conia twice a day to commence with. For a week she was better, with only one slight attack. The dose was increased to  $1\frac{1}{4}$  grains, and during the next fortnight she had one slight fit. She was then ordered back to bromide.

CASE 4. D., girl, æt. 7: has seven or eight fits a week, of a typical epileptic character. She has frequently right-sided convulsions, the right arm being suddenly flexed. Sometimes these culminate in a real fit, with insensibility and rigidity. The child is an imbecile. As while under 3 j doses of bromide, the child still had frequent fits, I ordered  $\frac{1}{4}$  grain of hydrobromate of conia three times a day. For the first week she had five fits (all occurring the day after the medicine was changed). For the second week there were seven fits. The drug was increased to  $\frac{1}{2}$  grain three times daily. For a fortnight she was absolutely free from fits, and then had seven. The drug was continued for some weeks, but she still had fits occurring at irregular intervals, which were refractory both to conia and potassium bromide.

CASE 5. E., female, æt. 27: has typical epileptic fits which continue under 3 j doses of potassium bromide. I administered  $\frac{1}{2}$  grain of hydrobromate of conia three times a day. During the next week she had no fits and stated that she felt better, but with frequent headache. For a month while under this treatment she had no fit, but complained of more frequent headache, in consequence of which I returned to bromide.

CASE 6. F., male æt. 18: would have three fits a day, and then go for a week without. They were typically epileptic fits. While under large doses of bromide they were kept under, but not until an unsightly bromide rash was established, which was troublesome to the patient. For the first week, while taking one grain hydrobromate of conia twice daily,

he had three fits. For a fortnight longer while under this treatment he had two fits. During the whole three weeks he therefore had five typical epileptic fits. As he stated that the drug made him feel giddy and weak, I returned at his own request to bromide, which so long as he was entirely under its influence in large doses seemed to ward off his attack. This young man was of weak intellect.

CASE 7. G., female, æt. 15 : suffered from true epilepsy, dilated pupils; her optic discs were congested. She had not menstruated and had phthisical symptoms (cough, hæmoptysis, sweating). Half grain doses of hydrobromate of conia were ordered three times a day. During three weeks she had no fit, which she stated was the longest time she had ever been without. I then lost sight of her.

The conclusions I draw from the treatment of these seven cases are—that the drug is undoubtedly serviceable in certain cases, and those in which it fails are cases of convulsions depending possibly on some gross lesion of the brain (Cases 4 and 6). The slighter cases (*e. g.* Cases 1 and 7) were distinctly benefitted by it.

The drawbacks to the use of the drug appear in the complaints of headache, and where in large doses, of giddiness lasting for an hour after taking it, with sometimes a suffusion and congestion of the conjunctivæ. In the doses in which I have given it, there has not been noticed any cardiac or respiratory alteration. It is said that the dose of this drug must not exceed  $4\frac{1}{2}$  grains in 24 hours, commencing with  $1\frac{1}{2}$  grains. In my experience a child of eight bore  $1\frac{7}{8}$  grains with only headache; a child of 7 took  $1\frac{1}{2}$  grains per diem, without any complaint:  $2\frac{1}{2}$  grains per diem, were taken by a female without complaint: one adult man took  $3\frac{1}{4}$  grains with impunity. In one case two grains per diem caused sickness, headache, giddiness, and "weakness" in a man of 18. One and a half to two grains appears to be followed frequently by headache. I think the drug deserves further trial. Combined with constant application of the continuous current, I have successfully treated with it a case of hemichorea. In this disease however, it would be rash to speculate whether the drug, the galvanism, or the time was the most effectual in the cure.—*Practitioner*, June.

#### THE TREATMENT OF DIABETES MELLITUS.

In the *Col. and Clin. Record* Aug. 84. Dr. Flint Jr. gives the following summary of treatment. He says:—"The more I study the cases of diabetes that have come under my observation, especially those that are now under treatment, in connection with the writings of those who have faithfully followed the dietetic plan, notably Bouchardat and

Cantani, the more thoroughly I am convinced that the prognosis in a recent and uncomplicated case of this disease in an adult is invariably favorable, provided, always, that the proper measures of treatment be rigidly enforced. In the hope of convincing the profession that this statement is reliable, I shall at the risk of what may appear to be needless repetition, give a summary of treatment, with brief statements of the progress of cases that I am now actually observing.

At the outset, patients should be impressed with the fact that they are suffering from a grave disorder, and that everything depends upon their full co-operation in the treatment, which treatment is essentially dietetic. The diet table should be carefully studied, and the diet regulated and carried out absolutely. In case a rigid anti-diabetic diet does not promptly influence the glycosuria, it may be well to subject the patient to an absolute fast for twenty-four hours and follow this with anti-diabetic regimen. This rather harsh measure is suggested by Cantani. I shall not hesitate to employ it in cases in which it may seem to be required, although no such case has yet come under my observation. Systematic daily muscular exercise should be enforced. A moderate system of training on the plan adopted by athletes is most useful; and this, if continued, will do much to render a cure permanent after a return to the normal diet.

The return to a normal diet should be gradual, and during this time the urine should be frequently examined, the rigid diet being resumed at the first reappearance of sugar in the urine; but all alcoholic excesses, the immoderate use of sweet fruits, and any use of sugar, should be interdicted at all times. A patient who has once had diabetes is always liable to a return of the disorder. He must lead a thoroughly careful, hygienic, and temperate life. In the words of Bouchardat, "you will not be cured except on the condition that you never believe yourself to be cured."

While I believe that the physician is justified in encouraging patients to expect relief, and even cure in recent, uncomplicated cases, the diet is all important, and its regulation cannot be expected to be perfect without professional aid in its enforcement. A diabetic is never safe from a return of his disease, even when he believes himself to be cured; and under no circumstances should he pass more than a few weeks without an examination of the urine.

The arsenite of bromide, or Clemen's solution, appears to be useful. It consists of arsenious acid and bromine dissolved in water and glycerine in such manner that two drops represent the 24th. part of a grain of arsenite of bromine. We may begin with 3 drops three times daily in a little water immediately after eating, gradually increasing the dose to 5 drops. This may be continued for weeks and months without producing any unfavor-



able effects; but the administration of this remedy does not supply the place of the dietetic treatment, which should be enforced in all cases. Cantani recommends lactic acid "lemonade" 1 to 2 drachms to the pint of water and flavored. A rigid diet should be continued for two months, at least, even in the mildest cases of the disease. It may be necessary, in certain cases, to continue it for a longer period, even twelve or more months. There is probably no such disease as intermittent diabetes. In some instances glycosuria occurs during the season of sweet fruits, when they are indulged in excessively, and disappears when the diet is changed; but these are mild cases of diabetes, excluding those in which a transient glycosuria follows the inhalation of irritating vapors, the taking of anæsthetics, etc. Robust or corpulent persons are more tolerant of the disease than those who are feeble or spare, and the glycosuria yields, in such cases, more readily to treatment.

Diabetes occurs at all ages. Bouchardat mentions a case in an infant of 3 years, although the disease is rare before the age of 12. The most unfavorable cases are those which occur before the age of puberty. An adult male presents the most favorable conditions for cure. In old persons, when the disease is of long standing, the dietetic treatment will secure practical immunity from nearly all the distressing symptoms, although the glycosuria may not be entirely removed. A study of any of the diet-papers recommended will make it evident that those who are able to follow the required regimen, without regard to the cost of articles of food, present much more favorable conditions, as regards the prospect of cure, than persons in straitened or indigent circumstances. Diabetes, however, occurs in all classes, and is by no means a rare disease. A hospital devoted to such cases, where the dietetic treatment could be strictly carried out, would be a boon to the rich and poor alike."

#### ANEURISM CURED BY DIGITAL COMPRESSION IN SIX HOURS AND A QUARTER.

In the *Brit. Med. Journal*, Arthur E. J. Baker, F.R.C.S., Eng., of University College, reports the following interesting case:

J. D., aged 36, was admitted into University College Hospital, under my care, on August 29th, 1883, suffering from an aneurism of the right popliteal artery. For this he had been already carefully treated, by M. Gandy, of Norwood, with a Skey's tourniquet, applied almost continuously for five weeks. This compression had had no effect upon the tumour. The patient was a particularly healthy, fresh-looking, cheerful man, whose personal and family-history were excellent, and

showed no evidence of constitutional disease of any kind. He had always been a gardener, working for the last eleven years in a very hilly garden, and doing all the work (which was very heavy) himself. This overstrain appears to have been the only exciting cause for the aneurism in this case. The appearance of the tumour dated from eight weeks before admission, when he first noticed pulsation in the ham. He was unaware of any special strain or other cause for it, and it gave him at the time no pain. Its size had remained the same since first observed. On admission, the swelling was of flattened oval shape, about two inches in diameter; it was tense and elastic, and pulsated strongly. It was seated exactly opposite the middle of the knee-joint, and was slightly red on the surface, having a distended vein on its outer side. There was aching pain on flexing the leg, but none when the limb was at rest in extension; some tenderness on pressure on the tumour was complained of, but none in the thigh or leg. Pressure on the superficial femoral artery arrested all pulsation in the sac.

Instrumental compression having failed, and the man being extremely anxious that something radical should be done, I ligatured the superficial femoral artery in Scarpa's triangle on September 6th, 1883. The operation was done in the usual way under spray, and the vessel was tied with a twisted silk ligature well carbolicised, which was cut short and left in the wound. The first ligature broke in drawing the second half of the knot; the next piece of silk bore the strain well, and was placed a quarter of an inch above the first spot chosen. The pulsation in the aneurism was now found to be completely controlled, and no pulsation was felt in it until about five hours later, when it was just perceptible. The tumour gradually shrank, while over it a small artery could be easily felt. The wound healed, without any trouble of any kind, by first intention throughout, the ligature showing no signs of coming away. The patient left hospital on October 1st, looking and feeling very well. At this time there was no pulsation to be felt in the tibial arteries, and no discomfort or pain anywhere. In this condition the patient remained at home until the second week in January, 1884, (about four months). He then noticed a return of pulsation in the right popliteal space, with pain in the knee as this gradually increased. A week later he came up to see me, when I found the aneurism almost, if not quite, as large as before the ligature of the femoral artery, although the latter, below the seat of ligation, was now pulseless, as were also the tibials. Above the ligature the vessel pulsated strongly. Pressure on the common femoral, below Poupart's ligament, completely controlled the expansile stroke in the aneurism, and from this there could be no doubt that it was fed by branches of the profunda, which had been



presumably enlarged during the five weeks of instrumental compression of the common femoral, which had preceded ligature. Of course here there could be no question of the ligature having dissolved away, as it was of strong silk, and the vessel was still pulseless below its seat; moreover, pressure on the femoral at this spot did not affect the aneurism, whereas pressure above the profunda did so at once.

I now determined to try digital compression, and, on the readmission of the patient on January 26th, he was put upon a somewhat restricted diet for two days, being confined to bed, and smartly purged. The effect of this treatment in lowering the arterial tension was most marked, and to it, no doubt, some of the good result may be attributed. Then, on the 28th, having a number of most willing volunteers from among the students, I commenced digital pressure of the common femoral at 10:50 A.M. This was carried out with the same attention to details referred to in my former case, and, at 5.15 P.M., all pulsation in the aneurism had ceased finally. Compression was still continued until 8 P.M., and then stopped. The temperature of the limb remained lower than the other for some time, but all discomfort and pain was soon gone. The patient returned home cured on February 5th. Since then, I have seen him several times; there has been no return of the aneurysm, which has shrunk up to small size. The pulsation in the tibials is still absent. The man is now engaged in his gardening work as before, without any pain or trouble from his former ailment.

#### EARLY SYMPTOMS OF CANCER— HUTCHINSON.

As Emeritus Professor, Professor of Clinical Surgery Mr. Hutchinson is now delivering his second annual course of lectures at the London Hospital. This course was instituted last year on the occasion of Mr. Hutchinson's retirement from the acting surgical staff, when he was appointed consulting surgeon. It was considered desirable to retain him as a teacher in connection with the Medical College, so he was made Emeritus Professor, and undertook to deliver six lectures annually on some subject connected with surgery.

The lectures for the present year are perhaps a greater success than those given last summer, and being wholly delivered extempore appeal more directly to the minds of the auditors. It goes without saying that Mr. Hutchinson gives no mere summary of ordinary text-book opinions, but lays before his hearers, in plain and unmistakable terms, the results of his own clinical experience.

On Wednesday, July 2nd, a good audience assembled to hear the lecture on "The Early Recognition of Cancer." The term "cancer" was used

in its clinical sense and as including sarcoma, and not in its limited anatomical sense applying solely to carcinomatous growths. The importance of its early recognition was obvious. Mr. Hutchinson said that before the actual presence of cancer was what might be termed the pre cancerous stage, and this was essentially a condition manifested by signs of local inflammation. An interesting case was narrated in support of this view. It was that of an old gentleman whom Mr. Hutchinson saw in consultation some years ago. One testicle had enlarged and was slowly increasing in size. The surgeons who saw the case agreed that it was probably not malignant and recommended non-interference. It continued to grow, however, and was at last removed solely by request of the patient, who had all along been anxious about it lest it should be cancerous. It was examined microscopically and was found to be simply in a condition of inflammatory hyperplasia, and no signs whatever of malignancy were discoverable. The patient recovered from the operation, no further trouble manifested itself, and his medical attendants came to the conclusion that his testicle had been unnecessarily removed. Two years elapsed. The remaining testicle then began to enlarge in the same way in which the other had done. Remembering the result of the previous operation, the surgeons strongly advised the patient against operation. As before, it continued to enlarge until finally it reached a considerable size. At last even the surgeon began to be alarmed and the patient's anxiety was extreme. The testicle was at last removed at the urgent request of the patient. It was examined and proved to contain a well marked sarcomatous growth. The inference was that the one first removed would, if allowed to remain, have also acquired a sarcomatous structure, and that the inflammatory hyperplasia found was a condition leading up to that of actual malignancy.

Eczema of the nipple preceding cancer was an illustration. Mr. Hutchinson remarked that cancer attacked parts that were functionally dead, as the breast in women late in life. Among animals it attacked the cat, the dog, and the horse, but not the sheep. The two former animals led a lazy life and were allowed to drag out their existence to old age. Sheep were usually killed before they were old enough to develop cancer.

The practical conclusion Mr. Hutchinson drew from his view was to treat as cancer all those cases where you suspected it—to adopt active measures at once and not wait for more decided symptoms until it might be too late.—*Med. Record.*

Oliver Wendell Holmes says that the great secret of success in every form of quackery is hope kept alive in the patient; while the too fatal gift of science is a prognosis of despair.

# THE CANADA LANCET.

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## MEDICAL SCHOOL OPENINGS.

The first of October is generally considered a red-letter day among medical students and professors in medical colleges in Canada and Europe. In many medical colleges both at home and abroad, it is customary to begin the work of the session with an introductory lecture on some general or special topic. In some the practice has been discontinued, and in others revived after a period of suspense. The beginning of the present session has been no exception to the general rule. Our exchanges bring us brief reports of the medical school openings in the mother-land, and the festivities which accompanied them in the form of hospital dinners and conversaciones. Some of these were on a grand scale of magnificence, and were the means of bringing together in friendly intercourse, old class-mates, fellow students, and professors. St. Bartholomew's, Guy's, St. Thomas', St. Mary's, King's, London, etc., vied with each other in the character and success of their respective festivities, and the friends and patrons of each turned out in force to do honor to the occasion. Although in Canada we have not yet inaugurated the festive part of the programme, we have not lagged behind in the "feast of reason." The introductory lecture is now a constant feature in all the medical schools in Canada, and in its general scope and character will compare favorably with those of a similar character in older and more favored countries.

The introductory lecture of the course in Trinity Medical College, Toronto, was delivered by Prof. Geikie, Dean of the Faculty. After welcoming the assembled class, he referred to the large graduating class of last year and the honor they had done the school and themselves by their successful examinations at home and abroad. Their example was held up as a model, and a like success was confidently predicted for all who would bring diligence and perseverance to bear upon their studies. The lecturer chose as his main subject, the history of the origin of medicine amongst the Egyptians, Jews, Greeks, and Romans, passing down through the centuries to our own times. He dwelt upon many medical superstitions, especially those connected with amulets and charms. He closed with a strong appeal to those present to prosecute their studies with that zeal and thoroughness which alone would lead to distinction during their college career, and throughout their entire subsequent professional life. He also earnestly cautioned them against giving way to any temptations to idleness or vice. They were urged to be very careful in the choice of their companions, and especially to steer clear of any who have the misfortune to rank amongst either the idle or the vicious.

At the Toronto School of Medicine the opening lecture was delivered by Dr. George Wright, who, after welcoming the students and referring to the success of the school, gave some timely advice to those about to enter the profession. He alluded to the interesting character of the study of medicine to the enquiring mind. The whole domain of nature, animate and inanimate, came under their observation in some way or other. They were now laying the foundation in professional work which was either to make or mar their success through life. He was a firm believer in the doctrine that each one had special adaptabilities, and the more accurately these could be gauged the more likely would be the success. He cautioned them against the tendency to be content with purely theoretical knowledge, and advised them to utilize all the advantages within their reach for the practical study of disease in all its varied phases. He deprecated any slipshod preparation in so important a profession and condemned the three years' course system. Brief addresses were also delivered by Drs. Workman, Thorburn and Richardson.

The opening lecture of the Royal College of

Physicians and Surgeons, Kingston, was delivered by Dr. Fife Fowler, Dean of the Faculty. He referred to the many successful students who had been educated in the College and who now occupy positions of honor and usefulness. Genius, accompanied by energy and application, could accomplish wonderful results; but the careful, plodding, persevering student often in the end succeeded in obtaining what the restless, fitful men of talent failed in accomplishing. He then referred to the motives which impel men in the race of life: that while some are urged on by envy, the love of success, or the love of money, the highest motive was the knowing and the doing of one's duty. Life should be viewed with exalted and purified minds, and the moral nature should be matured and elevated. The necessity of bed-side observation was strongly emphasized. The importance of being honest in thought, word, and deed, and the usefulness of acquiring business habits was referred to. He also dwelt on the importance of having such moral qualities as decision, courage, self-reliance, and individuality, and although their paths would not all be paved with daisies, he advised them to be of good cheer and arm themselves with prudence, fortitude and truth.

At the opening of the medical department of the Western University, London, Dr. J. M. Fraser delivered the introductory lecture. He referred to the good conduct and success of the students of the classes in previous years, and to the gratifying results of their efforts in the local examinations as well as at those of the Ontario Medical Council. He next referred to the responsibilities the medical student assumed on entering the profession, whose aims were to alleviate human suffering and prolong life. The responsibilities at the bedside of the sick and the suffering were of the gravest description, and required the highest cultivation and preparation, nicety of perception, calmness of judgment and an utter avoidance of self-seeking propensities or arrogance. He pointed out many of the solemn and sacred duties which the physician owes to his patient, or to the families of those with whom he comes in professional relation, and showed how necessary on his part was the exercise of kindness and sympathy. He pointed out the high aims before the student of medicine, noted the difficulties and obstacles to be overcome, indicated the vastness of the fields of medical science as yet unex-

plored or only partially understood, and expressed the hope that among those who, in the future, will be eminent in the profession and benefactors of the race, might be graduates of the Western University.

The opening lecture of McGill Medical College, Montreal, was delivered by Dr. Penhallow, Prof. of Botany in the University. The subject treated upon was "the relative position which the teaching of botany holds in the various schools in this country and the United States." The lecturer dealt with the question in an able and comprehensive manner, and was listened to with marked attention. Space does not permit our giving a digest. The prospects of the school for the present session are good, upwards of seventy new students having registered up to the 15th ult.

Up to the time of writing we have had no official reports from Bishop's Medical College, Montreal, or the Winnipeg Medical College, but have learned indirectly that their prospects for the present session are very good, the attendance being greater than last year.

The opening of the Women's Medical College here and in Kingston also took place on the 1st ult. The following extract from the address delivered by Dr. Alice McGillivray, at Kingston, may be taken as representing the sentiments of those who favor women entering the arena of medicine: Ladies, whatever your motive in undertaking this serious responsibility, whether it be from a desire to earn a livelihood or to provide against future contingencies, or from a realization of the many existent ills among those of our own sex, who shrink from seeking relief elsewhere, or in response to the appeal from the multitude of our suffering sisters in India, who are permitted to die unattended, we know each one of you will strive to achieve a high place as a student, to preserve all good grace becoming a lady, and in future to distinguish yourselves as much by your womanly dignity of character and goodness of heart as by your skill in the profession.

The number of those entering the profession seems to be ever on the increase. This year especially there would appear to be a much greater number than in previous years. McGill College, as before stated, has upwards of 70 freshmen. In the Kingston School the freshman class is larger than usual. The Toronto School of Medicine has

a goodly number. The number of freshmen in Trinity Medical School this session mounts above 100, the entire class numbering about 250. Abernethy's exclamation may well be reiterated: God bless you, gentlemen! What is to become of you all!

### THE QUEBEC LUNATIC ASYLUMS.

Grave complaints have been made from time to time for several years past by well-informed persons regarding the management or rather mismanagement of the asylums in the sister Province of Quebec. Dr. Hack Tuke, the well known alienist, who accompanied the British Association to Canada, availed himself of the opportunity to visit the asylums in Ontario and Quebec. The report of his visits to the Quebec Asylums was forwarded to the Hon. the Provincial Secretary, and has been made public. It is in truth a formidable indictment of the general management and moral treatment of the unfortunate insane in that Province. In regard to the cleanliness and order in the principal parts of the asylums there is much to commend; but in the upper stories and the refractory wards he finds "a skeleton in every closet." The wards are poorly lighted and ventilated, and almost destitute of any provision for the comfort of the inmates. One ward in the Longue Point Asylum, Montreal, he characterizes as a "chamber of horrors." In the corresponding portion of the building on the female side matters were no better—"a veritable pandemonium." Many were restrained by various mechanical appliances—muffs, manacles and straps—who should have been governed by moral restraint alone. They were closely huddled together and the atmosphere was stifling in the extreme. In the fourth story were the idiots and imbeciles, removed from all humanizing influence, treatment or education. The condition of the patients confined in the gallery, roof and basement, was beyond adequate description. In contrasting the condition of the asylums in Quebec with those in Ontario he says:—"The astonishment which I experienced in witnessing this relic of barbarism in the Province of Quebec is still further increased when I see such excellent institutions as the lunatic asylums of the adjoining Province of Ontario. I am certain that if it were possible to transfer the worst patients now in the asylum at Montreal to

these institutions, they would be freed from their galling fetters and restraint chains. They would quit their cells also, and, in very many instances, be usefully occupied where they are now restrained, with the result that in not a few cases perfect recovery to health would follow. 'Look on this picture and on that,' were words constantly in my mind after visiting the institutions of the two Provinces."

In discussing the cause of this lamentable state of affairs, he says, it is due entirely to the contract or farming system. This, it cannot be too often repeated, is the essential root of the evil, and unless speedily abolished will bear bitter fruit. In the conclusion of his report Dr. Tuke advises the Government to undertake the responsibility of providing the necessary accommodation and treatment of the insane poor, appoint resident medical superintendents with full authority, a competent board of management and efficient inspectors, and then the asylums would become institutions of which they would be proud instead of institutions of which they are now heartily ashamed.

### ANOTHER MALPRACTICE SUIT.

At the recent assizes in this city an action was brought by a patient named McClure against Dr. Grant, of Woodbridge. The plaintiff had the misfortune to receive a severe fracture of the leg from a kick in a drunken brawl. Dr. Grant was called in and treated the fracture by means of a fracture box, first applying a bandage to the limb. About the ninth day dry gangrene began to appear in the great toe. Dr. Stevenson, of Kleinburg, was called in consultation, and both he and Dr. Grant examined the bandage and came to the conclusion that whatever might be the cause of the gangrene, it was not due to the bandage. On the following day, Dr. Savage, of Thistleton, visited the patient in the absence of Dr. Grant, removed the bandage, and gave the plaintiff to understand that it was the cause of the gangrene. The gangrene then spread to the remaining toes and dorsum of the foot. After the line of demarcation formed, the anterior part of the foot was amputated by Dr. Savage, who had taken charge of the case, assisted by Dr. Heggie, of Brampton. In a few months afterwards the ankle-joint began to suppurate, and a second am-

putation was performed above the joint. The fractured bones and amputated foot were produced in court. There was fracture of the lower end of both bones, the fracture of the tibia being comminuted and extending into the joint, and the astragalus was fractured horizontally. The principal evidence for the plaintiff besides himself, was Dr. Savage, who was positive that the whole difficulty arose from the tightness of the bandage applied to the limb. Dr. Heggie at first thought the gangrene was due to the bandage, but said it might be due to other causes. Dr. Bull's evidence favored the defendant. For the defence, the evidence of Dr. Grant, and Dr. Stevenson went to show that every care had been exercised and that the bandage was not too tight at any time. Expert testimony, consisting of the evidence of Dr. Sullivan, of Kingston, Drs. H. H. Wright, Fulton, Bethune and others, of Toronto, was also brought forward, which went to prove that the accident itself was of sufficient severity to produce the gangrene, by injuring the anterior tibial artery, and that it could not have been caused by the bandage, inasmuch as the sole of the foot was not affected, and the gangrene was of the dry, instead of the moist variety. The judge, who was unable to comprehend the bearing of the expert evidence in the case, charged against the defendant, and the jury brought in a verdict for the plaintiff with \$750 damages. The case will be appealed. Comment on the unmanly and unprofessional conduct of Dr. Savage in this case is wholly unnecessary.

#### QUEBEC MEDICAL BOARD.

The semi-annual meeting of the Quebec Medical Board was held in Quebec on the 24th of Sept. under the presidency of Dr. C. E. Lemieux. There was a full attendance of members present. After the reading of the minutes a resolution of condolence was passed on motion of Drs. Guay and Beliveau, respecting the death of Dr. J. E. Landry, a member of the Board. The report of the examiners for the preliminary examination was read and adopted. Of 34 candidates 19 were admitted. The Treasurer, Dr. E. P. Lachapelle then read his report, which showed that \$5,322 had been raised during the past year, and after paying all expenses there was a balance of \$1,579 on hand. It also stat-

ed that the balance on hand was being continually diminished and suggested that means should be taken either to increase the income or lessen the expenditure, and a committee was appointed to enquire into the matter. The report of the detective showed that several actions had been instituted against illegal practitioners which were still pending in the courts. Dr. R. P. Howard, presented the report of the committee to enquire into the charges brought against the professors of Victoria College by Dr. Lachapelle, of having furnished copies of the questions to their students prior to the professional examination last spring. The consideration of the report was postponed until the next meeting. Notice of motion was given that at the next session of the Provincial Parliament a petition be presented praying for an amendment to clause 3, chap. iv. of the statutes and by-laws of the College of Physicians and Surgeons of Quebec, and that the words, "without examination" be replaced by the following, viz.: "after examination," the said examination to be upon the following subjects: medicine, surgical anatomy, descriptive anatomy, surgery, obstetrics, and materia medica.

The following gentlemen received the license of the college—Drs. P. Coote, M. R. G. Matte, E. Pelletier, E. Larue, E. Gosselin, J. A. Milette, A. Morin, F. S. Caron, E. Duval, C. N. Valin, M. T. Brennan, O. Berthiaume, F. H. Daigneault, W. Fournier, H. Leduc, J. O. A. Beaupré, H. Gauthier, R. Migneault, A. Richard, H. Brosseau, J. O. Stewart, A. Stewart, C. E. Cameron, J. A. Hutchison, and B. F. W. Hurdman.

**ACTION FOR SLANDER.**—This was an action brought by Dr. Hunter, at the recent assizes in this city, against Dr. Freel, both of whom reside in the village of Stouffville, Ont. Dr. Hunter attended a woman in her confinement. The labor was natural and the placenta came away without any trouble. On the fourth day afterwards she had a chill which was followed by an attack of pelvic cellulitis from which she died. Dr. Hunter complained that Dr. Freel, who had been called in the day before the woman died, stated to the friends of deceased that he (Dr. Hunter) had left a portion of the placenta in the uterus, which was the cause of the woman's death. This statement was also made to several parties in the village, and hence

the action. For the defence Dr. Freel called witnesses to prove that Dr. Hunter himself stated that he was afraid a portion of the placenta had been left in the uterus, and that the friends of the deceased mentioned this to Dr. Freel. His reply was "if Dr. Hunter left a portion of the placenta in the uterus it would account for the woman's condition," and this was essentially the statement he had made to other parties in the village. Dr. Hunter and his witnesses on the other hand testified that the statement was to the effect that if he (Dr. H.) had been obliged to remove the placenta a portion might have been left and caused trouble, but under the circumstances he could not account for her condition. A large number of witnesses, lay and medical were examined on both sides, and the trial occupied three days. In his charge to the jury the judge explained that any expression of opinion by Dr. Freel to the friends was privileged, but statements made to parties outside adverse to Dr. Hunter, or with a view to injure him constituted slander. The jury found a verdict for the plaintiff and \$50 damages.

**APPOINTMENTS.**—Dr. T. W. Mills has been appointed Prof. of Physiology and General Pathology in McGill Medical College, *vice* Prof. Osler; Dr. Wilkins, Professor of Practical Histology, and Dr. Sutherland Professor of Morbid Anatomy.

Drs. P. R. Inches, St. John, N.B. and J. H. McCollum, Toronto, have been appointed medical examiners under the Civil Service Act.

**CORONER.**—Dr. D. D. W. Harrington, of Halifax, has been appointed coroner for the City and County of Halifax.

**ACKNOWLEDGMENTS.**—The Chairman of the Ontario Board of Health desires to acknowledge with thanks contributions to their reference library of hygiene from the following publishers:—D. Appleton & Co., New York; A. E. Wilde & Co., Cincinnati; Henry C. Lea's Son & Co., Philadelphia; Jansen, McClurg & Co., Chicago; G. P. Putnam's Sons, New York; Houghton, Mifflin & Co., Boston; Harper & Bros., New York; Geo. S. Davis, Detroit.

**AMERICAN PUBLIC HEALTH ASSOCIATION.**—The 12th annual session of this association was held in St. Louis, Mo., on the 11th of October and three

following days, under the presidency of Dr. A. C. Ghion. About 150 members were present. A large number of interesting papers on sanitary questions were read and discussed. Dr. C. W. Goverton, President of the Ontario Board of Health, and Dr. Bryce, Secretary, were present as delegates from Canada.

**MEDICAL COUNCIL ELECTIONS.**—Dr. Allison, of Bowmanville, will again be a candidate for election to the Council for the Territorial Division of King's and Queen's. He has been a most able and faithful representative and we hope to see him re-elected. We know that the interests of the profession and the Council are very dear to him, and are in hopes that he will, some of these days, grant the institution a liberal endowment.

**MONTREAL MEDICO-CHIRURGICAL SOCIETY.**—The following have been elected officers of this Society:—President, Dr. Roddick; 1st Vice do., Dr. Alloway; 2nd Vice do., Dr. Trenholme; Treasurer, Dr. Molson; Secretary, Dr. Gurd; Librarian, Dr. Reed; Council, Drs. G. Ross, Kennedy and Rodger; Publication, Drs. Cameron, Ross, Bell and Kennedy.

**REMOVALS.**—Dr. Coleman, of St. John, N.B., has removed to Baltimore, U.S., to practice his profession. He carries with him the hearty good wishes of his Canadian confreres. — Dr. Atherton, of Fredericton, N.B., has removed to this city. We welcome him to our midst and wish him every measure of success and prosperity.

**TRIPLE VALERIANATE.**—Dr. Goodell recommends the following in the treatment of certain nervous diseases in females:

R Quiniæ Valerian.  
Ferri "  
Zinci " aa grs. xx.—M.  
Ft. pil. No. xx.

Sig. One three times a day.

**PRESENTATION.**—Dr. Aiken, of Weston, Ont., who is removing to California, on the occasion of his departure, was presented with an illuminated address, accompanied with a silver tea service for Mrs. Aiken, by his numerous friends in the village and neighbourhood.

**THE NEW LOCAL ANÆSTHETIC.**—The new local anæsthetic, cocaine hydrochlorate, recently discovered in Germany, is giving most astonishing and satisfactory results in the hands of specialists, as reported in the *N. Y. Medical Record*. Drs. Noyes, Agnew, Moore and Minor all speak in enthusiastic terms of its value. A few drops of a two per cent. solution is dropped in the eye three or four times at intervals during a period of fifteen minutes. The effect is to produce such profound local anæsthesia as to permit of operations, such as division of the recti muscles, being done without the patient complaining or showing any signs of pain. The new remedy is the reigning sensation in New York among specialists.

**STAMP CANCELLATION.**—We learn from the *Daily Star* that Dr. Griffin, of Montreal, has invented an instrument for cancelling postage stamps. It is stated that the loss to the governments of Canada and the United States through inefficient stamp cancellation, ranges from \$10,000 to \$50,000 respectively. The instrument will be tested in the Montreal post office, and if found satisfactory will be adopted generally. The instrument cuts a piece out of the stamp, but does not go through the envelope.

**THE BRITISH CHOLERA COMMISSION.**—The Commission, of which Dr. Klein is the principal, are busily prosecuting the work in Bombay, and have made experiments with the microbes which led them to doubt the infectious nature of Koch's cholera microbe. Dr. Klein has shown his contempt for the microbe theory by swallowing a number of so-called cholera bacilli without any ill-effects.

**COMPLIMENTARY DINNER.**—The medical profession of Montreal gave a complimentary dinner to Dr. Osler prior to his departure for Philadelphia. The chair was taken by Dr. R. P. Howard, and about fifty members were present, all of whom united in wishing their guest abundant success and prosperity in his new sphere of labor.

**MUNIFICENT DONATION.**—A donation of half a million dollars has been given to the College of Physicians and Surgeons, New York, by Wm. H. Vanderbilt. This is an example of generous and public-spirited liberality which is worthy of the highest commendation. It is to be hoped that it is only the beginning of good things in store.

## Books and Pamphlets.

**THE LAND OF BURNS, and other Pen and Ink Portraits.** By J. Campbell, M.D., Seaforth, Ont.

This interesting work by Dr. Campbell will be issued from the press in a few weeks, and the profession will, we are sure, be pleased to patronize it. The subject is an inviting one, and the author is quite competent to make it entertaining. We bespeak for the author and the work the kind consideration and patronage of the profession in Canada.

**HOOPER'S PHYSICIAN'S VADE MECUM;** with an Outline of General Pathology, Therapeutics and Hygiene. 10th edition. Revised by William Augustus Guy, M.B., Cantab, and John Harley, M.D., London, F.L.S. New York: Wm. Wood & Co.

The original work of Dr. Hooper, published as far back as 1823, has been such a great favourite with the profession, that every few years the proprietors of the original copyright have placed it in the hands of successive editors, by whom it has been brought down to the present level of the various subjects treated on. The work, as now presented to the profession, may be recommended as a useful reference to all items of information in clinical medicine, to both student and practitioner. Both volumes are largely illustrated by wood engravings, and an extensive collection of formulæ, preceded by classified lists of the British Pharmacopœia, with their doses, is added.

**MATERIA MEDICA AND THERAPEUTICS.** By Mitchell Bruce, M.A., M.D., London. Philadelphia: H. C. Lea's Son & Co.

This hand book is one of the very best of an excellent series. It is new, condensed and eminently practical in its character. It is divided into three parts: I. The inorganic. II. The organic materia medica. III. General therapeutics. This book, small in size, but large in the amount of information it contains, is sure to have a large sale.

## Births, Marriages and Deaths.

On the 15th ult., J. E. Brouse, M.D., of Brockville, Ont., to Amelia Mary, only daughter of P. L. Allen, Esq., of Hamilton, Ont.

On the 28th ult., the beloved wife of Dr. J. Fulton, editor of the CANADA LANCET, Toronto, aged 40 years.

On the 1st ult., Dr. J. A. Aikman, of Ingersoll, Ont.

On the 21st ult., Dr. J. S. Diamond, of Toronto, aged 45 years.



# THE CANADA LANCET.

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## Original Communications.

### NOTES ON FIVE CASES OF OVARIOTOMY.

BY A. B. ATHERTON, M.D., L.R.C.P. & S., ED., TORONTO,  
(Formerly of Fredericton, N.B.)

**CASE I, March 12, 1876.**—Mrs. H., æt. 49, never menstruated but once in her life, when 17 years of age. Had distinct menstrual molimen every month, however, till four or five years ago. Married at 22 years. Husband died seven years ago. Three years ago noticed first a tumor in left inguinal region. Was examined by me about a year afterwards, when it was of size of adult head, and I diagnosed ovarian tumor and advised her to have it removed when it got somewhat larger. Nearly a year after I saw her it had become so large that another medical man who was consulted tapped her. Since then he has repeated the operation some six or seven times. As the tapplings have of late been required at shorter intervals than at first, and as her health has been failing, she called me in again to see her. She was induced to do this, more particularly, because of the opinion of her attendant that the tumor could not be removed.

On examination I found the whole abdomen filled with a fluctuating tumor, also her legs were considerably œdematous, and she had become much emaciated. I advised her to submit to ovariectomy at once, but she begged me to postpone that operation for the present and tap her again. I complied with her request and drew off eight quarts of thick mucilaginous liquid. I tapped her again on May 4th, June 14th and July 16th, removing sixteen quarts in the last tapping.

**August 20.**—Thinks she is as large as before last tapping and consents to removal of tumor. To have castor oil to morrow to move the bowels.

**Aug. 22, 11 a.m., Operation.**—Chloroform administered, followed by ether; assistance rendered

by Drs. Coulthard and Ellis, of Fredericton. A long incision had to be made, extending two or three inches above umbilicus, to get out the solid portion of the tumor, which weighed eight pounds, and was so firmly adherent to the omentum that about nine inches of the latter had to be ligatured. The adhesions to other parts were unimportant. About eighteen quarts of fluid matter were got away by tapping, making the whole tumor about forty-four pounds in weight. It grew from left side. Pedicle secured by clamp externally and sutures put in. Stump powdered with salicylic acid and wound dressed with carbolized oil, cotton wool pad, and bandage being applied over all. Half a grain of morphine suppository given after coming out of ether.

**Aug. 30.**—Wound has been dressed every day as at first. Temperature reached more than 100° F. only once since operation; 100.5° F. on second day. Has not suffered much pain; taken five or six opiates; no vomiting; sutures were all removed yesterday.

**Sept. 2.**—Doing well, but bowels have not been moved till to-day, although she has had several enemata during the last few days. A dose of castor oil yesterday, followed by another enema this morning, has had the desired effect.

**Sept. 7.**—Clamp came off this morning. Doing well.

**Sept. 12.**—Is up, dressed, and going about the room.

**Sept. 18.**—Has been down stairs the last two or three days. Some granulations still at site of stump; nitrate of silver applied.

**Sept. 27.**—Wound healed; has been out of doors.

**Nov., 1884.**—Has been living in Boston the last five or six years, and has been in good health ever since operation.

**CASE II, March 21, 1878.**—Mrs. R. D., æt. 49, mother of four children, youngest nine years of age; husband living. Health generally good till one year ago, when she felt a lump in hypogastrium, accompanied with soreness. During last summer had two attacks of severe pain in abdomen, which obliged her to keep her bed about a week each time. Tumor has gradually, though irregularly, increased up to the present. Catamenia have been somewhat irregular, both as regards time and quantity. For the last month the appetite and general condition have failed, and she

now presents an emaciated and careworn appearance. Has consulted five different medical men in towns of New Brunswick and the State of Maine, who all seemed agreed that she was suffering from a tumor which was "connected with the womb," and gave it as their opinion that it could not be removed. Her family physician called her husband to one side just as they were starting from home to consult me, and told him that if she was operated on she would be brought back a corpse.

On examination I found a large hard tumor occupying the whole of the lower abdomen, somewhat irregular on its surface, and at one or two points indistinctly fluctuating. Slight resonance in left lumbar region; dull elsewhere. Per vaginam: os tincae felt directed somewhat posteriorly, and sufficiently patulous to admit the tip of forefinger. Fundus of uterus anteflexed, and tumor pressing closely down upon it; the two seemed to move together more or less in all directions. Sound could be passed only one inch. When the tumor was however lifted well upwards by Dr. Coburn, of Fredericton, who assisted me at the examination, I could enter sound the normal distance by directing it well anteriorly, and I then found that the uterus and tumor could be moved more or less independently of each other. On aspirating tumor at a point which seemed to be more fluctuating than the rest, a small quantity of thick mucilaginous fluid was got. I therefore diagnosed an ovarian tumor, and advised operation. While resting after her long journey for a few days, the catamenia came on.

*March 31, 11 a.m., Operation.*—Chloroform administered, assisted by Drs. Coburn and Ellis. Incision below umbilicus and tumor tapped. Only a pint or two of fluid got away, and I therefore extended incision upwards to above navel. Some adhesions on the front and left side, were readily broken down, and the tumor delivered. Clamp applied to pedicle and secured externally. Sutures; carbolized oil dressing, with cotton wool and bandage. Pedicle sopped with tinct. benz. co. Half a grain of morphine suppository after operation.

*April 5.*—Wound dressed every day as at first. Has required four or five opiates; considerable vomiting for the first thirty-six hours; attributed it partly to the milk given. Since then has eaten

soda biscuit and tea. Temperature has not risen above 99.2° F. since operation. May chew a little beefsteak to-day. Two sutures removed.

*April 7.*—Abdomen has been considerably distended for the last day or two, and yesterday evening pulse and temperature ran up to about 100° F. No great pain or tenderness, however. All sutures removed yesterday. Patient feels as if bowels ought to be moved, and I therefore ordered oil, to be followed in a few hours by enema.

*April 8.*—Bowels moved twice with some griping last night, and I ordered quarter grain suppository of morphine, which caused her to rest well till morning. Pulse 76, temp. normal. Some suppuration in stitch holes.

*April 18.*—Has done well since last report. As clamp has not come away, and the stump is swelling rather badly, I cut the latter close beneath clamp and took it away. There was no bleeding, as the parts were completely dead.

*Nov., 1884.*—As far as known, continues well to date.

*CASE III, Oct. 24, 1878.*—Miss T. R., æt. 18. Health usually good; catamenia always regular since 13. First noticed some enlargement of abdomen last February. Consulted Dr. Holden, of St. John, N.B., in June, who diagnosed ovarian tumor, and treated her first with iodide and bromide of potassium; of late he has put her on tonics. Abdomen has steadily enlarged, till now it measures thirty-three inches around umbilicus. It fluctuates everywhere. No marked change from health in the general appearance, but she has suffered a good deal of pain in part for a few days past. Ordered opiates pro re nata.

*Oct. 27.*—Has required quarter grain doses of morphine two or three times in the twenty-four hours; vomiting has been somewhat troublesome from it. Pulse 96, temp. normal.

*Oct. 30.*—Pain not so severe; pulse 108, temp. normal.

*Nov. 4.*—Pain has subsided; pulse 96.

*Nov. 9.*—Chloroform given and a vaginal examination made. Cervix uteri was in normal position. Anteriorly, a firm mass filled roof of pelvis. The hymen being perfect, this examination was not very satisfactory.

*Nov. 11.*—To have half an ounce of castor oil to-night, followed by an enema in the morning.

*Nov. 12, 11 a.m., Operation.*—Chloroform ad-

ministered, assisted by Drs. Holden and Coburn. Incision made, under carbolic spray, four inches long, between umbilicus and pubes. Tumor tapped and about ten quarts of thick syrupy fluid removed. No adhesions. Tumor grew from right ovary. Pedicle ligatured with carbolized silk and dropped in. About half a dozen sutures put in, and dressed with carbolized gauze. Adhesive straps over this, and cotton wool and flannel bandage. Half a grain of morphine suppository, together with quarter grain hypodermically, was required to relieve pain after the operation.

*Nov. 15.*—Dressing changed for first time under spray. Wound looks well. Has complained a good deal of pain in abdomen and down right thigh since operation, for which she has had two or three opiates per day. This has seemed to keep up some vomiting, but the temperature has only been up to 100° F. once, on the morning of the 13th. Pulse now 104, temp. 99.5° F.

*Nov. 18.*—Doing well; no opiate since the 16th. An enema brought away some fecal matter and a good deal of wind yesterday.

*Nov. 19.*—Wound dressed; sutures removed. Small spontaneous motion of bowels to-day.

*Nov. 22.*—Wound dressed with adhesive plaster. No pus has been seen at any time.

*Nov. 29.*—Sitting up for last two days. Pulse 100, temp. normal. As bowels have not moved for several days, some citrate of magnesia was ordered.

*Dec. 4.*—By dint of citrate of magnesia, castor oil, and enemata, a large quantity of hardened feces has been got away during the last few days.

*Dec. 14.*—Doing well; is about house. Gaining in flesh and strength.

*Nov., 1884.*—Was married a little more than three years ago, and has since borne two children.

*CASE IV, March 13, 1879.*—Miss M., æt. 27. Came to me from the country yesterday; gives as a reason for not coming before, that the doctor in her neighborhood always told her that nothing could be done for her. As she began to think that death must soon come, she decided as a last resort to consult me. Was generally healthy till six years ago, when she first noticed an enlargement of the abdomen. No distinct lump ever felt. She has steadily increased in size till she now measures seventy-two inches around body at umbilicus, sixty-six inches around waist, and fifty-six from one

anterior superior spinous process of ilium to the other. Has not suffered very much pain, and has had no difficulty with bladder or bowels. The catamenia grew gradually more and more scanty, till they ceased about two years ago. The upper part of her body is extremely emaciated, while the abdominal walls and legs are immensely swollen. Many large veins course over abdomen. The lower end of sternum is pressed so much outwards that it stands at right angles to axis of body. When standing on feet the oedematous abdomen reaches quite down to upper edge of patellae, and when she sits, it rests upon the seat of chair between the thighs. The upper half of abdomen distinctly fluctuates, but the great oedema below prevents my getting this sign clearly. Per vaginam, the hymen acts as an obstacle to a satisfactory exploration. Per anum, a soft doughy mass can just be touched with finger at roof of pelvis. Pulse 120, weak and thready.

*March 14.*—Thinking it better to tap the tumor, and thus take the pressure off the kidneys and allow them to remove the anasarca condition somewhat before proceeding to abdominal section, I passed in a long curved trocar with point downwards, and drew off seven gallons of thick treacly-looking fluid. The size of patient did not seem much reduced by the operation. At the end of the flow there came away about an ounce of purulent-looking fluid.

*March 15.*—Patient rested pretty well last night, but complains a good deal of soreness, which she thinks is largely due to my keeping her quiet in bed since yesterday. She therefore asks to be up, as is her custom. I consented, with the understanding that she should not move about the room. Measurement is now sixty-two inches about umbilicus, and fifty-seven inches around waist. Pulse as before. A slight hacking cough, which has troubled her for a few months, has left her since the tapping. This is probably due to removal of pressure from lungs.

*March 19.*—As there seems to be little or no improvement in patient's general condition, and as she is urgent for an operation, I agree to remove tumor on the morrow; bowels to be freely opened previously.

*March 20, 11.30 a.m., Operation.*—Ether administered, assisted by Drs. Coulthard, Coburn and Ellis. On making incision I found tumor exten-

sively and firmly adherent in front and right side, to abdominal wall; and this, together with the great size of the solid portion of tumor, necessitated a wound reaching nearly from ensiform cartilage to pubes. Several gallons were got away by tapping, and after three or four hours' hard work, the whole tumor was removed. Pedicle was ligated and dropped in, mass being cut away from left side where it grew. A considerable amount of blood was unavoidably lost during the operation, and brandy had to be given both by mouth and rectum while it was going on. Large rubber drainage tube put in at lower wound, and sutures introduced as usual. Operation was done under carbolic spray, and the wound was dressed with carbolized gauze. Strapping, cotton wool, and bandage over it. Ninety-one and a half pounds of tumor removed, thirty-nine and a half pounds constituting the solid portion. 6 p.m.—Pulse feeble, and occasionally intermittent; a good deal of restlessness. Two drachms of laudanum and half an ounce of brandy given in water by the rectum. 7 p.m.—Sleeping quietly. Pulse rather better.

March 21, 9 a.m.—Pulse 140, feeble, but regular. Extremities warm. Has had brandy, milk and egg, by both mouth and rectum during night. Urine drawn; it looks well. 12 m.—Pulse 148. Considerable serous discharge on dressings, which were therefore changed. 3 p.m.—Pulse more feeble. Some delirium. 4.30 p.m.—Pulse absent at wrists. Extremities growing cold. 9 p.m.—Died. Abdomen examined; no hæmorrhage.

CASE V, *March 28, 1883*.—Mrs. A. G., æt. 50. Multipara. Has not been very strong since marriage, thirty years ago. Had a "fever" when pregnant seven months with first child, and miscarried at eight months; child living. Thinks she has never entirely recovered from the effects of that illness. Has had more or less dysuria for years, though urine, she states, generally looks healthy. More troublesome than ever since two years ago, at which time she thought there was a tumor in the vaginal passage. Eighteen months ago, underwent an examination by a physician of a neighboring town, who told her that she had a "fibroid" tumor of size of fist at the back of womb. Catamenia have been tolerably regular, though she sometimes has gone beyond the four weeks. Appetite has been poor of late. Abdomen is now about size of that of a woman at full term. This

enlargement is due to a hard irregular mass, most prominent on right side. Very little if any fluctuation can be detected in it, though in parts it seemed somewhat elastic. Per vaginam, uterus felt at right anterior pelvis. Sound enters normal distance. A mass, similar to that felt through abdominal wall, and apparently continuous with it, found pressing down well into pelvis posteriorly. Uterus moved independently of tumor. Lumbar and epigastric regions alone resonant on percussion. Pulse 84, temp. 99° F.

April 6.—Catamenia appeared the next day after last examination, being the proper period for them. Pulse 88, temp. 99.

April 9.—Took a cathartic yesterday evening, preparatory to an operation, and had two loose stools accompanied with some griping. Paregoric relieved latter. Pulse 92, temp. 100.

April 11, 12 m., Operation.—Chloroform administered, followed by ether. Assisted by Dr. Coburn, and Mr. J. G. Owens, my medical student. Carbolic spray used. Incision from just above umbilicus to near pubes. Tumor tapped and about three quarts of thick material got away. The solid portion, weighing about seven pounds, was then removed. No adhesions of importance. Tumor grew from left ovary. Pedicle ligatured with silk and dropped in. Wire sutures. About a dozen catgut ligatures had to be applied to various bleeding points of wound in abdominal wall, long continued pressure with forceps not controlling the hæmorrhage. Carbolized gauze, etc., as in cases 3 and 4. Suppository, containing half a grain each of morphine and ext. belladonna, administered. On examination of tumor nearly a pint of thick, flaky, purulent matter found scattered through its solid portion.

April 12, 9 a.m.—Rested fairly. Pulse 92, temp. 100. Vomited only once. 9 p.m.—Pulse 96, temp. 100.8.

April 13, 8 p.m.—Pulse 76, temp. 99.4. Some menstrual flow appeared to-day.

April 14.—Pulse 72, temp. normal. Wound dressed under spray.

April 19.—Bowels were moved by enema two days ago. Sutures removed to-day under spray. Wound about healed. Pulse 76, temp. 98.6.

April 25, a.m.—Patient sat up for an hour last evening; while up she suddenly got chilly, and was obliged to go to bed at once and be covered

up warmly to avoid a rigor. Some pain was complained of in left side running up towards axilla, which was relieved by half a grain of morphine suppository. Not much pain this morning, but pulse is 100 and temp. 101.4. 6.30 p.m.—No great pain to-day. Pulse 110, temp. 103.4. Wound is all right, and there is little or no distension in, or marked tenderness of, abdomen. Nothing wrong per vaginam.

*April 27, 9 a.m.*—Has had half a grain of morphine suppository and rested fairly well. Pulse 104, temp. 101.4. 8 p.m.—Pulse 100, temp. 103.2.

*April 28, 9 a.m.*—Has perspired rather freely this morning. Pulse 80, temp. 99.2. 8 p.m.—Pulse 84, temp. 101.6.

*April 29, 10 a.m.*—More free perspiration last night. Pulse 76, temp. 98. 9 p.m.—Sweating continues. Pulse 72, temp. 98.

*May 2.*—Has been doing well since last report, and has returned to solid food with a relish.

*May 12.*—Left for home, about 90 miles away.

*Nov., 1884.*—As far as I am aware, has remained in good health up to the present time.

**REMARKS.**—There are several points in the above cases which are worthy of notice. In the first place, in four out of five the long incision had to be made in order to get out easily the solid portion of the tumor. The favorable result in three out of the four would rather indicate that the increase of risk is not so much as generally believed when the incision is extended above the umbilicus.

Secondly, the much abused clamp was used to secure the pedicle externally in the first two of these, and they both did exceedingly well.

Thirdly, the presence of pus in Cases 3 and 5, showed that before long there would have been an escape of matter into the peritoneal cavity, and consequent death.

Fourthly, the immense size of the tumor in the patient who died. I removed at least 147½ lbs. from her in six days; and supposing the sac re-filled to the extent of 20 lbs. during those days, the tumor must have originally weighed 127½ lbs. I may mention that Dr. Thomas Keith, to whom I related this case last April, considered 20 lbs. a liberal allowance for its increase during that period. My own impression is that I gained nothing by the preliminary tapping in that case, for I think that she was if anything weaker *after* it than *before* it; and I attribute her increased weakness (when

ther rightly or wrongly) to the rapid re-filling of the emptied cyst, causing a great drain upon the nutritive principles of the blood. If I should ever meet with such an enormous tumor again, I would at once proceed to ovariectomy.

Finally, the feverish turn which occurred in Case 5, was, I believe, due to some kind of blood poisoning, causing a short continued fever. I had noticed on several occasions, both before and after its occurrence, a foul smell in the hall adjoining her room. I had called the nurse's attention to it, but neither she nor I could ascertain the source of it. I can't help thinking that this had something to do with her febrile attack. There was nothing at any time in the wound, or, as far as I could detect, in the abdomen, to account for it. It will be observed that her temperature reached only one evening as high as 100.8° F., in the first week after the operation, while during the second week it had been normal. It could therefore be scarcely possible after such a period of favorable convalescence, that the operation had anything to do with the febrile attack. I may say that this patient was one of those who are very gloomy, and she fully expected not to live beyond the ninth day. She disclosed this fact to me only after that day had passed, although she had me sent for hastily on several occasions during the 8th and 9th days, imagining that her time was at hand.

I may further observe that in all these cases I had no skilled nurse to look after the patients, not even one who had done other kinds of nursing; so that it is evident one may get very fair results in ovariectomy in remote districts where such are hard to procure, as well as in hospitals peculiarly equipped for such operations. I am free to admit, however, that the assistance of a nurse accustomed to the care of such cases, would lessen materially one's own anxiety and the amount of attention required to be given to them.

#### A CASE OF DOUBLE NARCOTIC ADDICTION.—OPIUM AND ALCOHOL.—IMBECILITY—RECOVERY.

BY J. B. MATTISON, M.D., BROOKLYN, N.Y.

Through the courtesy of Drs. T. Gaillard Thomas, of New York, and Wm. Bayard, of St. John, N.B., there came under the writer's care last

year a case of combined opium and alcohol taking, presenting a history and result of such importance as probably to render its recital one of interest to the readers of the LANCET.

Mrs. —, of Canada, æt. 34, in the summer of 1881, passed through her second accouchement during the eighth month of gestation. Her recovery was tedious, involving four to five months, during which she had much discomfort from alvine torpor, and also underwent an operation for the relief of fistula in ano. The latter was attended by severe pain, to relieve which her medical adviser gave morphia hypodermically, and supplying her with a syringe instructed her and the attendant in its use. This was in July, and the initial dose of the morphia was  $\frac{1}{8}$  of a grain, repeated three or more times daily, when the pain was severe. She made a fair recovery from this illness, except that the power of her lower limbs was largely lost, due, it was thought, to the morphia—which she had steadily taken—and a lack of active exercise. She had now become a confirmed habitué, and during the next two years used her opiate in increasing quantity and frequency, often repeating it every three or four hours.

During the autumn of 1883 she came under the care of a medical gentleman who was called to relieve her of severe abdominal pain and nervous derangement. Prior to this time no attempt had been made to abandon the morphia. Her new medical adviser, appreciating the situation, strongly urged an effort in that direction, but without success. Her condition had steadily grown worse, aggravated as it was by an inordinate use of brandy, of which she took at times from 12 to 16 ounces daily. From October, 1883, her mental and physical decline was marked, the most prominent symptoms being anorexia, insomnia, nausea, incessant thirst, subsultus, loss of memory, delirium, hallucinations and partial imbecility. Her physician now insisted on stopping her stimulants, and succeeded with the brandy, while the morphia, which had been increased to several grains, three to five per diem, was reduced to one or two injections daily. Despite this treatment her mental and physical status steadily deteriorated until she became completely imbecilic, and in this condition, on December 21, 1883, she came under the writer's care.

So weak was she prior to leaving home that

some of her friends deemed it hazardous to make the effort, fearing she would not survive the journey, but under the watchful care of Dr. Bayard, it was safely effected. Her physical debility on arriving was so great that she was carried from her carriage. Mentally she was a wreck. Delusions were prominent, and hallucinations of sight, sound and touch almost constant, that of touch being especially marked, patient fancying bugs and reptiles crawling over her. Her expression was idiotic; she was utterly unable to converse intelligibly, and her voice in speaking speedily sank to a whisper and was lost. In fact such mental ravages from opium we never met. Physically, she was partially prostrated, pulse frequent and feeble, marked anorexia, furred tongue and alvine torpor; in fine, all the symptoms before noted except delirium and subsultus. During her coming, in order to maintain her strength, she had taken milk punch freely, and was given one or two half grain injections of morphia daily. Such was her status on arrival. There was no history of hereditary insanity. The case seemed clearly one of profoundly pernicious results from her double addictions, aggravated by a laudable effort to remove the cause. This being our belief, the prognosis was favorable, an opinion endorsed by Dr. John C. Shaw, Superintendent of the King's Co. Insane Asylum, who was called in consultation, and verified by the result, as the further record of the case will show.

As a prelude to active treatment the patient was given a mild mercurial which acted well. No alcohol was allowed from the outset, and at the end of a week the morphia—which previously had been given in small doses by mouth at bed-time—was quite abandoned, and reliance placed on large doses of Indian hemp to secure sleep. As tonics she was given daily seances of electricity, with syr. of the hypophosphites of iron, strychnia and quinine, in two drachm doses, ter die, and full feeding. The good effect of this *regime* soon declared itself, for in less than a fortnight, signs of improvement presented. The earliest of these were mental. The delusions lessened and the hallucinations departed, the last to leave being those of touch which persisted for some time after the patient was able to realize that they were only the vagaries of her disordered brain. With this amendment came a better brain status in other

ways. The imbecilic look gave place to one of increasing intelligence; the power to converse rapidly returned, and within six weeks all mental aberration had vanished. Meantime, the physical condition gradually improved, though not so speedily as the mental. The appetite was slow in returning, but her muscular strength, especially in the lower limbs, the loss of which for two and a half years, had prevented exercise, increased steadily, so that at the end of eight weeks she was able to take walks, drives, go shopping, attend church, etc., in fact, more out of door exercise than she had enjoyed for years. Her improvement in every way was notable and persisted with little interruption until March 4—nearly eleven weeks from the date of her coming—when she left our care. Tidings, direct and indirect, of late received, report her doing well.

This case presents several points worthy of detail. Its origin affords added proof in support of views expressed in "The Genesis of Opium Addiction," *Detroit Lancet*, Jan. 1884. But it must also be said that, in our judgment, the course of the medical gentlemen in supplying this patient with a hypodermic syringe and solution of morphia, with instructions for self-taking, unless absolutely unavoidable, was—to put it mildly—exceedingly indiscreet. Such action and advice are almost certain to end in addiction; the effect, even under professional attention, is, too often, disastrous, and the chance of escaping, when left to caprice of the patient, is small indeed. We believe that patients should *never* be allowed to give themselves injections, if at all possible to avoid it.

When her initial illness ended, this patient was an opium habitué. A much more limited time than that will often suffice. We have repeatedly known as many weeks to beget addiction, and the most marked examples of this were among those in whom it might be supposed the least likely to occur—physicians. Increased experience serves only to strengthen the writer's opinion, as expressed in a paper on "Opium Addiction among Medical Men," that "any physician using morphia, daily or oftener—especially hypodermically—for four weeks incurs great risk of becoming an habitué; indeed we think a still shorter usage might, with some, prove a snare." This case adds another to the instances in which addiction to one narcotic tends to excess in another. While these are infrequent

as compared with those in which one is used, they are sometimes quite notable. We recall that of a Canadian gentleman who some time ago consulted us, who had taken for several years 10 to 20 grains of morphia subcutaneously, 60 to 90 grains of chloral, and 1 to 2 pints of whiskey, daily. Physical examination disclosed organic heart lesion, and care of his case was declined. As a rule, the ruinous results exceed those of a single addiction, while the prospect of permanent cure is always less hopeful. In our patient the pernicious effect on the brain was notable—more so than we have ever seen. While deviations from normal cerebral action are sometimes observed in cases of confirmed opium taking, it is rare that they are so pronounced as in this instance. Doubtless they were aggravated by the alcohol, yet morphia was the main factor. And it is of interest to note that the attempt at renouncing the narcotics intensified the mental disorder. Obersteiner—*Brain*, Oct., '82—demurring to Levinstein's statement that the psychical disturbances caused by morphia cease within a few hours, affirms that "mental diseases arising in the course of morphinism are of the most intractable kind when once fully developed. Not only do they not disappear on depriving the patient of morphia, but they then usually get worse."

This case tends to prove the latter part of his statement. As one medical gentleman informed us—"The condition in which you saw her was the result of the addictions aggravated by the attempt to quit them." But the mental disorder was *not* of the "most intractable kind," for improvement was prompt and progressive, much more so than anticipated, as it was thought several months rather than weeks would be needed to repair the damaged brain.

Regarding alienation caused by opium, Obersteiner thinks it frequent, asserting that "a man who consumes large quantities of morphia during a number of years will display many nervous symptoms, and that the continued intoxication attacks the psychical much more constantly than the somatic life." He further states: "The degree of mental aberration arising from protracted use of the drug is very variable. There may, indeed, be individuals who retain their power of mind in spite of it, but the number is much greater of those who betray a marked alteration of their intellectual and



moral life; and in not a few cases finally the point of distinct aberration is reached. This usually consists of a depressed state, with suicidal tendencies, occasionally with violent excitement and hallucinations;" and he sums up his views with the statement that "In most cases the protracted use of morphia in large doses is followed by psychical alterations of a lasting nature, which may amount to decided insanity."

With these opinions we are not in full accord. Our experience has been much more favorable. We have observed many cases of opium addiction, among them those who had taken morphia in large amounts for several years, yet the number with marked mental derangement has been small. Depression has been common; so, too, irritability of temper; but we recall only one instance in which suicidal or homicidal tendency existed, and but a single case that we deemed "decided insanity." Far oftener physical symptoms presented. In some form, these have been almost constant, so that, on this score also, our observation has been at variance with Obersteiner.

Regarding treatment, one point deserves special mention—that is, the effect of Indian hemp in large doses. In this instance it quite maintained the power ascribed to it by Moreau of removing hallucinations. Again and again, often by the patient, was this noted. Its hypnotic action also was very satisfactory. As a soporific, in ex-opium habits, cannabis indica is of great value. They may be peculiarly susceptible to its good effect, but certain it is we know of nothing equalling it, and employ it almost exclusively. For details regarding its use, *vide* "The Treatment of Opium Addiction," *Courier of Medicine*, Dec., 1884. Finally, the history of this case is of value as warranting hope of entire recovery under conditions that, seemingly, offer little promise of success.

## COCAINE AS A LOCAL ANÆSTHETIC.

BY A. M. ROSEBRUGH, M.D.

Surgeon to the Eye and Ear Dispensary, Toronto.

The surprising effects which have been attained during the last few weeks, with the muriate of cocaine, has led me to collect some facts in regard to it, for the benefit of the general reader.

Cocaine hydrochlorate is prepared from the

leaves of the *erythroxylon coca*. The plant grows wild in the mountains of Peru and Bolivia in South America, where it is used instead of tobacco. It is estimated that thirty millions of pounds per annum, are consumed by the natives who chew the leaves made into a ball mixed with lime. When used in moderate quantity, it is said to increase nervous energy, enliven the spirits, and enable the person to bear bodily exertion, exposure, and want of food to a surprising degree.

The physiological action of the alkaloid (cocaine formula  $C_{17}H_{21}NO_4$ ) is apparently identical with that of theine, and caffeine. The alkaloid was discovered in 1855. In large doses it produces cerebral excitement, complete paralysis of sensibility, tetanic spasms, and death. It paralyzes the entire posterior column of the spinal cord and the entire system of peripheral sensory nerves.

The hydrochlorate of cocaine has been used for over two years for the purpose of reducing the sensitiveness of the larynx, but it was not until about the first of September last that its anæsthetic effect upon the conjunctiva and cornea was discovered. The honour of this discovery is due to Dr. Koller, a young physician of Vienna. The discovery was announced at the meeting of the International Ophthalmological Society, held in Heidelberg September 15th and 16th, the report of which appeared in the *N. Y. Medical Record*, October 11th, and in the *Ophthalmic Review*, a little later. Since then the anæsthetic properties of cocaine in ophthalmic as well as in some other branches of surgery has been very thoroughly tested, and with the most gratifying and surprising results. Up to the present, the only salt of cocaine used is the hydrochlorate which is used in solution of from 10 to 20 grains to the ounce. For producing anæsthesia of the conjunctiva and cornea, from two to four drops are applied every three or four minutes until from eight to twelve drops are used. Partial anæsthesia commences within two minutes of the first application, reaches the maximum in about fifteen minutes, and disappears in twenty-five or thirty minutes. Under its influence, the eye-speculum may be introduced, the conjunctiva seized with the fixation forceps, the eyeball fixed in any position, and all the ordinary operations may be performed without pain. When the solution is applied only superficially the anæsthesia does not seem to extend to the ocular muscles or to the iris. Before perform-

ing tenotomy ether for strabismus or for enucleation, the hypodermic syringe is used, and before excising a section of the iris the cocaine solution is allowed to enter the anterior chamber through the corneal wound. I have found cocaine useful in facilitating exploration of the eye. This is of special advantage in treating children and highly sensitive patients. It relieves photophobia and removes the dread of manipulation. Whether or not it possesses actual therapeutic value remains to be seen. It will be at least a valuable adjunct to other remedies.

In addition to its anæsthetic properties, it dilates the pupil and diminishes the power of accommodation. As these effects all disappear in a few hours, cocaine will probably supersede atropine for ophthalmoscopic examinations, and especially so as I find that the eye is more tolerant to the light of the mirror when under its influence.

Cocaine hydrochlorate has already been applied as an anæsthetic and with encouraging results, to the mucous lining of the nasal cavities, the pharynx, the urethra and vagina. Under its influence the actual cautery has been applied to the turbinated bones, the catheter has been introduced into an unusually sensitive male urethra, and operations have been performed upon the os uteri, with little or no pain.

Cocaine has been found to contract the venous sinuses underlying the Schneiderian membrane, hence it is suggested as a remedy in acute, coryza hayfever, and epistaxis. It also exerts a controlling effect upon the painful affections of the eye, as in iritis, in the phlyctenular diseases, and after operations and injuries; and it has been used with success in painful affections of the ear.

The price of the new remedy one month ago was as high as one dollar a grain, but it can now be obtained for 50 cents. The price is still too high to admit of its general use, but in important operations such as iridectomy and extraction of cataract, where general anæsthesia is attended with serious drawbacks, cocaine would not be too dear at one dollar a grain; and even at that price the cost would not be greater than in using the best sulphuric ether.

QUININE AND ERGOTINE.—Ergotine neutralizes the cerebral effects of quinine. Tinnitus may be entirely avoided by combining these two remedies.

## COMPOUND FRACTURE OF THE SKULL, ESCAPE OF BRAIN SUBSTANCE, RECOVERY.

BY H. ROSS, M.D., CLIFFORD, ONT.

Permit me to give a few details of a case that occurred in my practice between three and four months ago. R. B., æt. four years, while playing on the lower steps of an outside basement stair at the rear of the dwelling, was struck on the head in the right frontal region by a brick which fell from a second storey window, a distance of eighteen feet. The child fell but rose again almost immediately, ascended the stair and was finding her way into the house, when met by her mother.

I saw the case a few minutes after the accident. The child had vomited two or three times before I arrived, but showed no other symptoms of having received a severe injury. On examination, I found a scalp wound about an inch and a half in length, which had bled freely, and amongst the hair a quantity of brain matter, in all about the size of a large marble. The mother had previously wiped a quantity of blood and brain matter from the wound. In the then excited state of the child, I found it impossible to make a proper examination of the wound, or with any degree of safety to ascertain the extent of fracture, without the use of an anæsthetic. I therefore sent for Dr. Stewart, of Palmerston, to assist me, and in the meantime placed the head in the position most favorable to drainage; applied cold to the head by means of iced water conducted through a bladder by rubber tubes of entrance and exit, provided with stop-cocks to regulate the supply. And as there were no symptoms of depression or shock, except perhaps the vomiting, I gave a sharp purge of calomel and jalap. On the arrival of Dr. Stewart, we chloroformed the patient, and on examination found the fracture to be about one inch longer than the scalp wound and situated three or four lines lower on the frontal bone, owing probably to an oblique position of the head when struck. There still remained debris of brain matter between the edges of the wound, and on closer examination, the strongly pulsating torn end of an artery (a branch of the anterior or middle meningeal, most likely the latter), which had been ruptured by the injury, was seen projecting from between the edges of the

fracture. The lower edge of the line of fracture was found depressed the entire thickness of the skull, and the vessel appeared to be compressed by the edges of the fracture to an extent sufficient to prevent hæmorrhage. It is reasonable to suppose that the depressed edge of the fracture recovered its position to some extent after the injury, partly from its own resiliency and partly from brain pressure, so that the hæmorrhage which had apparently been free at first, was arrested by the pressure exerted on the bleeding vessel by the re-approximation of the edges of the fracture. The peculiarity of this case is, not the recovery of the child, for recovery is not so rare an occurrence, especially in children, after brain injuries with loss of brain substance; but what seems singular in the case is the fact, that with the one exception of vomiting, the child never gave any indication of having received a severe injury of any kind, from the day of the accident up to the present time. She never betrayed the slightest want of intelligence from first to last, and a few minutes after the accident, as well as throughout her confinement to the room up stairs, readily recognized the voices of her associates who were playing on the street below. It seems to me, the only reasonable explanation of the absence of brain symptoms, and one which is concurred in by Dr. S., is that the extrusion of brain substance caused by the continued action of the violence which produced the injury, while relieving to some extent the brain pressure, by carrying with it the already severed artery, also saved the child from the immediate and remote effects of extravasated blood in brain tissue. I need scarcely say, that in the absence of symptoms, and of any spicula of bone which might irritate the brain, we did not interfere with either the fracture or scalp wound, but secured perfect quiet in a moderately darkened room, a position favorable for drainage, the continuous application of cold to the head for many days, regular action of the bowels, and the use of cold water dressing to the wound, which healed kindly in a short time; and after a few days it was with difficulty that the little patient could be restrained from playing with the other children when she heard their voices on the street, and for the last two or three months she has been playing about the streets, as lively as the best of them.

## CASE OF MOLAR PREGNANCY COMPLICATED WITH PUERPERAL URÆMIA.

BY E. H. WILLIAMS, M.D., C.M., L.R.C.P., LOND.  
(Toronto General Hospital.)

N. A., æt. 21, admitted to hospital Oct. 4th, said to be suffering from rheumatism. It was soon ascertained that she was pregnant about three months. A dark, offensive discharge was observed from the vagina. A bath was carefully taken by patient, after which she soon began to flow, somewhat profusely. As she denied anything like labour pains, it was thought the progress might be stopped, and accordingly (the os being only slightly dilated), perfect quiet was enjoined, and full doses of black haw, opium and cannabis indica, administered. It soon became evident, however, that this was of no avail, and a plug, of the kite-tail form was introduced, and replaced by another in 6 hours, which second remained in 8 hours, when the os was found dilated. During this time ergot was given by the mouth, but provoked vomiting after a time. The uterus was then easily emptied of a mass having a feel of placenta, but which proved to be a much hypertrophied decidua containing an imperfectly formed amnion, with a number of black clots beneath it. No trace of what could be called an ovum could be found among the clots or anywhere in the mass. Several semi-organized clots were taken out of the uterus, and  $\frac{1}{2}$  a drachm of ergot (F. Ext.) administered hypodermically (into the gluteus). All went well for a while, but that night the patient was unable to sleep, so that small doses of pot. brom. and tr. lupuli. were given. About 2 a.m., however, was called up, and found patient very restless and irritable, trying to get out of bed.

A catheter was used, and about 2 ounces of urine drawn off, which was found to contain about  $\frac{1}{3}$  albumen, *sp. gr.* 1.011. Pulse 145, and rather feeble; temperature 102 $\frac{3}{4}$ . Hot fomentations were applied over the loins, and more blankets put over her, and a mixture of liq. amm. acet., spts. æth. nit. and fl. ext. jaborandi given. Hot water bottles were applied to feet. Diarrhoea had by this time set in, and was not stopped. For a while perspiration was free, and in the morning she seemed better as regards pulse and temperature, but in a state of semi-delirium, which seemed to lessen towards noon, when she became suddenly comatose, with dilated pupils, stertorous breathing,

etc., and died in a very short time. There was no sign of a convulsion from beginning to end, and from the beginning of threatening symptoms until death (about 12 hours) there were about 7 oz. of urine secreted. She admitted having taken oil of juniper on one occasion to procure abortion. Had given birth to a healthy child 3 years before.

*A P. M. Examination* was made by Dr. Teskey, and the following conditions found: The *heart* weighed 11 oz., and the valves were healthy.

*Lungs*, oedematous and congested.

*Liver* (4 lbs, 8½ oz.) congested, edges thickened, and a tendency to fatty degeneration.

*Spleen* (16½ oz.) congested, soft and friable.

*Uterus* (8½ oz.)—no signs of peritoneal or cellular inflammation around uterus. Ovaries and corpus luteum normal. The os uteri was scarcely dilated, but slightly ecchymosed on its inner surface. A few small clots were found on the inner surface of the body of the uterus.

*Kidneys*,—capsules adherent in places, tissues markedly congested, light and dark streaks running from the centre peripherally. A small abscess was found in the right kidney near the pelvis.

The *cranium*. Vessels of dura mater congested, and a milky appearance of the pia mater at the upper part, the whole brain presented a "wet" appearance.

Considerable serum was found in the subarachnoid space, especially at the base, and also in the lateral ventricles, of which the lining membrane was opaque. The choroid plexuses were much congested. No emboli could be found in the cerebral vessels.

A microscopical examination of the kidneys was also made by Dr. Teskey.

Pathological changes were most marked in the cells of the convoluted tubules. These were found enlarged, angular, and mostly separated from the walls so that many had fallen out in the process of mounting, leaving the tubules naked. The cell contents were markedly granular, the nuclei not readily seen, and the lumen of the tubes small, irregular, and choked by broken epithelial cells in many places, especially near the boundary area. The glomeruli were somewhat enlarged and hypernucleated with thickening of Bowman's capsule. The inter-tubular tissue was also increased in thickness and nucleation. No marked changes were found in the tubules of the pyramids.

## THE NEW LOCAL ANÆSTHETIC, HYDROCHLORATE OF COCAINE—EXPERIMENTS WITH CAFFEINE.

BY R. A. REEVE, B.A., M.D.

Senior Ophthalmic and Aural Surgeon, Toronto General Hospital—President, Toronto Medical Society, etc.

It is not surprising that the virtues of a drug which is at once absolutely non-irritant and equally anæsthetic to the urethra and conjunctiva, the cornea and drum-head, and the mucous membranes of the larynx, naso-pharynx, vagina, etc., should be promptly and widely tested and heralded. The various indications it fulfils will be so apparent as hardly to need specifying. The following cases illustrate in part its potency, and one is cited, not without interest, in which it proved useless. The solution used was of four per cent. strength, the two per cent. having been found too weak, as a rule, for operations upon the eye.

CASE 1.—J. A. Toronto General Hospital, Iridectomy, Nov. 11th. Four applications in fifteen minutes; operation begun five minutes after the last; no pain,—“just felt the doctor was doing something.”

CASE 2.—J. T. T. Sclerotomy for secondary glaucoma,—drug useless. Six instillations (of several drops) in twenty-five minutes; operation attempted five minutes later, but patient not tolerating the use of knife or forceps, chloroform had to be used. The patient was a very nervous subject, and there was possibly idiosyncrasy in addition to evident hyperæsthesia.

CASE 3.—Mrs. McC. *Operation for secondary cataract*: solution applied three times in ten minutes; discission ten minutes later. The patient, a nervous lady, said she “felt not a bit of pain.”

CASE 4.—Mrs. T. *Mucocele; Bowman's operation*: three applications on punctum and inwards; canaliculus slit as far as caruncle without pain, and into sac with but little; pupil moderately dilated, but contracting to light and on accommodation.

CASE 5.—Mrs. M. *Iridectomy for inflammatory glaucoma*: five instillations upon upper margin of cornea in fifteen minutes; five minutes later, section at sclero-corneal junction not felt; solution dropped upon wound holding knuckle of iris; two or three minutes later segment of iris excised. The patient, a delicate nervous lady, said “she only felt the operation a little.”

CASE 6.—M. C. æt.  $3\frac{1}{2}$  years: *Staphyloma of cornea*: Fifteen minutes after a single instillation, the cornea was incised, without complaint.

CASE 7.—Mrs. C. The galvano-cautery was applied to several points on the septum and turbinates after the use of the solution, without other discomfort than fleeting neuralgia of superior dental nerves.

CASE 8.—Ulceration of larynx. A two per cent. solution gave marked relief of irritability.

CASE 9. — *Inflammation of auditory meatus*. Solution dropped into ear; tenderness and pain sensibly relieved—"a sort of numbness."

CASE 10.—E. L., Toronto General Hospital. *Iridectomy*. Five applications in forty minutes; operation ten minutes after the last; section of cornea not felt; the seizure and excision of iris gave some pain.

CASE 11.—F. G. H. *Pterygium*. Four applications; abscission and suturing practically painless.

CASE 12.—N. McL. *Strabismus*. Four instillations in fifteen minutes; tenotomy five minutes later; moderate pain caused by traction upon muscle with hook, but none in cutting tendon; pupil not dilated in thirty minutes.

Under cocaine, extraction of cataract is not more painful than iridectomy; and more frequent droppings or stronger solutions than the four per cent. may be found to anæsthetize the iris—a safer plan apparently than injecting into anterior chamber. Cocaine may be used to prevent (or mitigate) the after pain of operations in various parts and lessen risk of secondary inflammation. It will doubtless prove valuable for relief of pain, photophobia and spasm of orbicularis from corneal irritation, as well as of reflex ills elsewhere, of kindred origin. The writer has been disappointed in not finding an 8 or 10 per cent. solution of the alkaloid itself in oleic acid anæsthetic to the skin; but the aqueous solution of the salt can be utilized hypodermically for local anæsthesia, to some extent at least. In solution or unguents of various strengths, it should allay the pain of burns, &c., and the itching in some skin diseases.

EXPERIMENTS WITH CAFFEINE.—Influenced by the alleged identity of the general physiological, if not therapeutical, effects of caffeine and cocaine, the writer was led to test the former, hoping that it also might prove to possess local anæsthetic

properties; but a four per cent. solution failed to appreciably lessen the sensitiveness of his own conjunctiva. Bearing in mind that caffeine is only one-sixth of the strength of cocaine as regards systemic effects, a much stronger solution of caffeine\* was next tried, namely; twelve per cent. on the patient, case 1, in whom the anæsthetic properties of cocaine (4 per cent. sol.) had been quite decided; but the conjunctiva remained sensitive, and grasping it with forceps caused pain. This would seem to shew that caffeine is not a local anæsthetic; a fact to be regretted, because it can be had pure and cheap, and the supply is unfailing, while it would seem good coca leaves are seldom imported.

## Correspondence.

To the Editor of the CANADA LANCET.

SIR,—To save other medical men from sharing the fate of Dr. Rabbeth, of the Royal Free Hospital, London, who recently lost his life by sucking through a tube the secretions from the trachea of a diphtheritic patient upon whom he had performed tracheotomy, I communicate to you the following. A few weeks ago I performed tracheotomy on a little girl about eight years of age, for relief from the consequences of acute laryngitis. Three days after the operation an attack of broncho-pneumonia supervened, and the secretions became so copious and were at the same time so tenacious, that it was found impossible to keep the tracheotomy tubes clear, and to prevent suffocation in a terrible paroxysm, I was obliged to withdraw the tubes entirely and trust to the larger opening thus secured for respiration and the escape of the secretions. After the removal of the tubes respiration continued very imperfect and labored, owing to a large quantity of mucus still remaining in the trachea, and for the extrusion of which the patient could not muster sufficient expulsive force. At this juncture I went to my office, a short distance, for an India-rubber bulb and tube, with which to suck out the accumulation, leaving my partner, Dr. Henderson, and a couple of students with the patient. During my absence, another violent paroxysm of suffocation came on, and Dr. H., by means of a rubber tube, sucked out some of the mucus, and one of

\*Though bought from a reliable house it may prove on analysis to be impure.

the students did the same thing. Nothing more was thought of this until about three days after, when Dr. H. complained of a sore throat, the parts being highly inflamed, dark in color, and covered with diphtheritic patches. He continued very ill for eight days, and some part of the time fears were entertained as to the result. The student, a day or two later, was taken in a similar manner, though not so severely, and was a week sick. As the rubber bulb would not draw sufficiently to be effective, another means was thought of, as it was evident that the expulsion of the secretions would for a long time require external aid.

The aspirator came next to our minds, and on trying it we found that we had all we could desire. The needle was removed and a small rubber tube, about eighteen inches in length, was attached. Whenever the secretions collected so as to be troublesome, the tube was inserted through the wound into the trachea, the bottle exhausted, the stop-cock turned so as to open the entrance, and powerful and effectual suction was at once accomplished. As soon as the bottle became filled with air, it was again exhausted, the stop-cocks shut, and the apparatus thus prepared kept at hand ready for use. For several days and nights this contrivance was kept in almost constant demand, and most undoubtedly saved the patient's life.

This is not worthy of the appellation of a "new discovery," but it certainly is a new application of a most useful instrument, and one that should never be forgotten for cases requiring this kind of treatment. Valuable lives have been sacrificed by the act of sucking secretions out of diseased throats; and notwithstanding all the cautions against the practice given by our best authors, ambitious and impulsive young practitioners will occasionally risk their lives by performing it. In a late number of the *Brit. Med. Jour.* there is a cut showing the construction of an instrument for use in such cases, consisting of two rubber tubes connected by a hollow glass bulb for receiving the matter as it is sucked out, and to one end is a mouth-piece attached for the operator. But all this is useless, as long as we admit the germ theory of contagion; the air from the diseased parts, no more than the secretions, should pass into the mouth and throat of another. With the aspirator used as I have pointed out, all danger of contagion is avoided; by the use of a large bottle a more powerful suc-

tion can be exercised than can be by the mouth; and by regulating the stop-cock, it can be made to act powerfully or feebly, can be suddenly started and stopped, and the whole apparatus kept ready for instant use. Better than turning the stop-cock every time one wishes it to act, while sucking out collections of mucus, is to compress the tube between the thumb and finger with which it is held; for the suddenness with which it can thus be made to act renders it far more efficient in picking up partially hardened and isolated portions. The aspirator, then, should be one of the instruments of the laryngotomist, and of every one who attends cases in which matter has to be removed from the larynx and windpipe by external force.

Yours truly,

THOS. R. DUPUIS.

Kingston, Nov. 17, 1884.

[A writer in the *London Lancet*, Nov. 8th, 1884, after claiming to have used the aspirator in this way during the past nine years alludes to the defects in the apparatus owing to the air being drawn into the trachea by the side of the suction tube, and recommends the addition of a piece of wash-leather about 6 x 6 to the tube. A piece of vulcanite tube is passed through a small hole in the centre of the wash-leather, which is tied firmly. The suction tube is then passed through this and into the trachea. The wash-leather is moistened and spread over the neck of the patient, and effectually prevents the entrance of air alongside the tube. ED. LANCET.]

## PROFESSIONAL ADVERTISING.

To the Editor of the CANADA LANCET.

SIR,—Under the above caption a recent number of the *LANCET* refers to an ex-president of the Nova Scotia Medical Society who occupies half a page in announcing his "Private Infirmary," in Belcher's Farmer's Almanac. It also states that, "this same gentleman issued a circular on the eve of his departure for Europe in which he modestly states that he expects to visit the larger special hospitals of England, France and Germany, and to bring back 'increased stores of knowledge' together with 'new surgical apparatus.'" And now the town of Amherst, N.S., scores another on this count. A medical man who practiced in a village in that section of country and achieved considera-

ble of a certain species of notoriety, finding it desirable to remove, also went to Europe, and in a short space of time comet-like returned with an immense appendage composed of a large number of the letters of the alphabet. He is now astounding the public and the profession by his announcements of "increased stores of knowledge," and the possession of a marvellous 'new surgical apparatus,' costing him "a thousand dollars, and which is unknown to the surgeons of Canada or the United States." By means of this 'instrument' he "will be enabled to successfully carry and apply infallible remedies directly to all or any of the internal organs of the human body."

Apropos of the above in the *Maritime Sentinel* newspaper there recently appeared the following: "Dr. H— successfully removed from the neck of Miss Marney a tumor of three year's standing. The difficulty of removing this tumor was from its being situated among the large blood vessels of the neck." The profession will doubtless be surprised at the surgical and anatomical knowledge possessed by our newspaper reporters, and their simplicity of description for popular reading and edification. The sources from which such articles usually originate are sufficiently apparent and the above is a good illustration. It will not be less surprising when it is stated having been positively ascertained from several practitioners who had been consulted, that the tumor was a very small fibrous growth situated just beneath the skin, about the middle, and below the margin of the left inferior maxilla, and which was "successfully removed" by making an incision at right angles to the jaw bone, leaving a cicatrix more disfiguring than the tumor, which was its greatest discomfort. This matter was allowed to pass unnoticed although perhaps by coincidence an article appeared in the following number of the *Lancet* dealing in general terms with such subjects as the above, and which would have been sufficient to deter any but the most unscrupulous and adventurous from the repetition of such acts.

Nevertheless in a more recent publication of the *Maritime Sentinel*, occurred the subjoined paragraph:—"Dr. H.— successfully removed from the mouth of Miss Austin of River Philip a tumor of four months' standing which had grown rapidly until it was the size of a hen's egg. Miss Austin had just returned from the hospital at Halifax

where they declined to operate. She is doing well." Now this second flagrant violation of the code following so closely upon the other, cannot be permitted to pass, and after careful enquiry into the case, and observing correspondence in the public prints relating to the matter, the following references will place the subject in its proper light. A communication from a medical man to one of the papers calling attention to the repetition of such unprofessional conduct, elicited an answer from an anonymous correspondent, and which was refused publication on account of its "style and inuendoes," and it ultimately transpired that the "reporter" of the "surgical operation" and the anonymous correspondent, was a proxy, prompted and dictated to by the ubiquitous surgeon in question in order to shield himself from the responsibilities of his acts. By reference to the books of the hospital it cannot be found that such a patient ever applied for treatment, and careful enquiry from undoubtedly reliable sources goes to prove that the tumor was a ranula and the "successful removal" consisted in the introduction of the point of the lancet! And now applying the principle of "*similia similibus curantur*," we have decided to introduce the point of the *Canada Lancet* into this benign (?) surgical neoplasm. You have well written it, Mr. Editor, that "our confreres down by the sea are not to be outdone in the matter of advertising."

Yours truly,

A HALIFAX SURGEON.

Halifax, N.S., Nov. 14th, 1884.

[Professional, or rather unprofessional, advertising seems to be a growing evil, and is not confined to any particular Province or locality. One of our city papers recently contained a most glowing account, in black letter heading, of "A Terrible Operation," "A man's tongue cut out to save him from an awful death," performed by one of our own colleagues of the Toronto Hospital staff. When such "things are done in the green tree, what shall be done in the dry?"—ED. LANCET.]

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### Reports of Societies.

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#### CHICAGO MEDICAL SOCIETY.

*Reported for the Lancet.*

At the regular semi-monthly meeting of this society, Dr. E. Andrews presented a report of the



following cases: Two cases of gastrotomy, two cases of excision of the rectum. Remarks on litholopaxy, and exhibited a new instrument for varicocele.

Dr. S. V. Clevenger read an elaborate treatise under the head of "Political Abuse of the Insane."

Drs. B. and J. Bettman read interesting papers on hydrochlorate of cocaine, illustrating its use in ophthalmic and nasal surgery. The physiological and therapeutical effects of the alkaloid may be tabulated as follows:

(1) Hydrochlorate of cocaine is a powerful local anæsthetic, not penetrating in nature, rapid in its effects, which however are only temporary.

(2) It is a mydriatic, the effect of which is regulated by the strength of the solution.

(3) It produces paralysis of the ciliary muscle, the near point receding from the eye—distant vision is not influenced.

(4) By virtue of its benumbing powers it may be classified as an anodyne.

The following cases were cited, where the drug was used to produce local anæsthesia: Operation for dilatation of the nasal duct; removal of a piece of steel from the cornea, the same having been embedded for two days; operation for cataract; cauterization of the inferior turbinated bones; and to relieve the pain in otitis media acuta purulenta, in each of which it gave the most gratifying results.

The following report was presented by the Committee on "National Sanitation," and adopted. It is really written in the interest of the National Board of Health of the U.S., and was first suggested by Dr. Montgomery, the Secretary of the Society:

The committee appointed at the meeting of this society, Sept. 15th, 1884. to consider and report upon a series of resolutions presented by Dr. L. H. Montgomery, having reference to national sanitary matters, respectfully report the following: That in the judgment of this Society, the sanitary interest of the United States demands the establishment of a permanent national health authority, which shall have for its main functions the detection of pestilential and epidemic diseases, and the enforcement where necessary of sanitary regulations tending to prevent, abate, or suppress them. That a committee of three be appointed by this Society, to collate facts tending to show the

usefulness and necessity of a national sanitary organization, and to compile the same in such form as may be available for disseminating information upon, and creating an interest in national sanitary legislation. That the said committee be empowered and instructed to urge the importance of national legislation upon the attention of the congressional delegation from Illinois, and fittingly to present the subject to representatives of the people in both houses of Congress. All of which is respectfully submitted.

O. C. DEWOLF, *Chairman.*

## Selected Articles.

### EXOPHTHALMIC GOITRE—CATARRHAL JAUNDICE—LYMPHADENOMA—CATARRHAL NEPHRITIS—INTERSTITIAL NEPHRITIS—SPECIFIC DISEASE OF THE SPINAL CORD.

CLINIC BY PROF. BARTHOLOW.

#### EXOPHTHALMIC GOITRE.

This case was also before the class a short time ago. It is a case of exophthalmic goitre, presenting the usual quartenary of symptoms, although the fourth was not so distinct as the others. There are present: protrusion of the eyes, enlargement of the thyroid, which, in this case, however, is not as great as it often is, and rapid action of the heart. The fourth symptom of this affection—dilatation of the vessels—was not so well marked. In severe cases the thyroid gland pulsates with the force of an aneurism. In addition to these symptoms there is, as a rule, marked anæmia. This was a prominent feature of this case.

The treatment which she received, and which acts very favorably in cases of even severe exophthalmic goitre, consisted in the administration of the following pill:—

R.	Extracti ergotæ,		
	Ferri sulphatis,	aa	gr. xxx
	Strychnine sulph.,		gr. ss. M.
	Ft. pil. No. xxx.		

Sig.—One three times a day.

There has already occurred a marked improvement, and I have no doubt that by a persistence in this treatment the symptoms will gradually subside.

I also pointed out, when this patient was first before you, that in the treatment of uncomplicated cases of exophthalmic goitre there is no remedy so successful as galvanization of the cervical sympathetic. I have repeatedly seen symptoms of a violent character disappear under the use of galvanism,

the positive electrode being applied in the fossa, behind the angle of the jaw, and the negative on the epigastrium. A current of from ten to thirty cells is used, according to the condition of the patient and the amount of reaction. The stable galvanic current is the proper one. The applications should be made daily for ten minutes at a time. This will tone up the sympathetic, which is the seat of the disorder; it will moderate the action of the heart, contract the dilated vessels and diminish the size of the thyroid. I am particular in saying that the constant galvanic current will cure uncomplicated cases of exophthalmic goitre, and I must insist on that proposition. There are many cases in which complications exist, the most usual being in the heart and great vessels. Such lesions, being permanent, cannot be removed by such a remedy. On the other hand, there are certain cases which are entirely uncomplicated, in which there is purely a functional derangement of the sympathetic system. That functional derangement is entirely removed by galvanic stimulation.

We must, however, not lose sight of the fact that the treatment is not directed solely to the ganglia of the sympathetic, for if one electrode be placed behind the angle of the jaw and the other on the epigastrium, there are within the circuit not only the cervical sympathetic, but the pneumogastric, the descendens noni and the cardiac branches of the sympathetic.

#### CATARRHAL JAUNDICE.

In this case the diagnosis is comparatively easily made. Looking at this patient, you see that he is jaundiced; the conjunctiva is very yellow, and the skin has a distinctly yellow tinge. Let us now turn to the history, for the history of every case needs to be very carefully investigated; and in a case like the present, the history may of itself furnish the data for a diagnosis.

Three weeks ago the patient began to feel distress in the epigastrium. Taking but a small quantity of food into the stomach sufficed to bring on a choking sensation, and caused him to feel filled up. There has been more or less nausea and occasional attacks of vomiting, and this was especially marked during the past week, when he vomited six times. The tongue is coated with a thick, yellowish fur, which is especially marked on the left side. The passages are whitish, and entirely wanting in their normal color. I inquired whether the stools were mal-odorous, for, as you know, bile prevents the decomposition of the food, and when the bile is wanting, the food may undergo ordinary putrefactive decomposition, and the stools in consequence, may be very offensive. The bile evidently does not flow into the intestine, and we see that it passed backward into the blood. It being eliminated by the kidneys, as shown by the appearance of the urine.

How much pressure is required in front to make the bile pass back into the blood? It has been ascertained by actual observation, that if there is catarrh of one-half an inch of the ductus communis choledochus, with swelling of the mucous membrane at its termination at the duodenum, this will produce sufficient obstruction to prevent the flow of bile into the intestine, and cause it to pass back into the blood.

There are supposed to be two forms of jaundice, hepatogenous and hematogenous. In the former the jaundice is due to reabsorption of the bile; in the latter to the disorganization of the red blood globules.

In the present case we have a history of gastrointestinal trouble followed by jaundice. We know that these attacks of biliary disturbance are exceedingly common in malarious districts. This man has been living in a malarious section of the country until the past three months. Malarial poisoning may cause jaundice in two ways; first, by producing a catarrh of the ducts, and second, by its action on the hepatic cells. We know that in chronic malarial toxæmia, the hepatic cells are crowded with bile pigment. It is probable that the poison which causes malaria acts directly on the hepatic cells, increasing the formation of pigment, and favoring its deposit in the body. In this case there is a distinct malarial element, which has much to do with the disturbance. This has a practical bearing, for these cases, although they may present no obvious malarial trouble, are not readily cured without the administration of an antiperiodic.

Taking these things into account, we come to the conclusion that this is a case of catarrhal jaundice, and that there is also a malarial element.

Such is the therapeutical diagnosis. What are the most useful remedies? The phosphate of sodium is the most efficient remedy for causing the catarrhal process to disappear, and to favor the flow of the bile into the intestine. It will be given in drachm doses three times a day. In this case it will be advantageous to combine with it the arseniate of soda in the dose of  $\frac{1}{30}$  of a grain three times a day. We must not disregard the malarial impression. I will direct the salicylate of cinchonidine five grains three times a day. This is a most efficient substitute for sulphate of quinine in ordinary malarial attacks.

#### LYMPHADENOMA.

At first sight this case may not seem of much importance, but in reality it is of great importance. There is, as you see, a bunch of enlarged glands on each side of the neck. The axillary glands are also enlarged, and I also find that the area of splenic dulness is increased.

That disease characterized by progressive enlargement of the lymphatic glands, by splenic changes and profound anæmia, is known as lym-

phadenoma. Such cases are progressive, going from bad to worse, and, ultimately, if not properly treated, have but one ending. Is this a case of that kind? At this stage it is almost impossible to say. It may be enlargement of the glands due to strumous disease. I am inclined, for two reasons, to doubt this. In the first place, there is no evidence of strumous disease in any other part of the body, and, in the next place, there is enlargement of the spleen; and the spleen is not only enlarged, but it is firm. Then the characteristic progressive *anæmia* is not wanting.

Lymphadenoma is a constitutional disease. The gland elements undergo the changes known as hyperplasia and hypertrophy—enlargement of existing elements and formation of new elements.

Various measures have been proposed for the relief of this disorder. It has been suggested that the hypertrophy of the glandular system may be arrested by the extirpation of those first affected. It has been found that if the glands be removed early, the disease being limited to one group, we can prevent its spread beyond the glands first involved, showing that there is something generated in the first set of glands which undergoes multiplication and which gradually affects the glands of the body generally.

The treatment must be both systemic and local, the latter being the most important. Internally, probably more good has been done by phosphorus than by any other remedy. It is best given in  $\frac{1}{10}$  grain doses, dissolved in a drachm of cod-liver oil, three times a day. Good effects have also followed the use of the syrup of the iodide of iron and manganese. These may be given in combination with the phosphorus. I have found ergot to do great good in a case now in my hands.

As I have said, the most important part of the treatment is the local treatment. The best local remedy is injection of arsenic into the affected glands. The amount of arsenic said to have been used in some cases is almost incredible, as much as thirty to sixty drops of Fowler's solution having been injected at a time. In practicing the injection, ether spray or a piece of lint moistened with chloroform, is applied, to benumb the skin. The hypodermic needle is then inserted and a few drops of Fowler's solution thrown in. The injections should be practiced on alternate days. Various other things have been used locally. Injection of iodine has been employed, but it is much more painful and less efficacious than arsenic.

What is to be done for the enlarged spleen? Our German colleagues are in the habit of injecting arsenic into the spleen. They do this with apparent impunity and with great apparent good. I might enumerate many other remedies but the most important are phosphorus with cod-liver oil, and the injection of arsenic.

#### PARENCHYMATOUS NEPHRITIS, PROBABLY SPECIFIC.

The interesting cases now presented have such characteristic symptoms that you can almost make the diagnosis at a glance. The first patient is a woman, 47 years of age. The arteries are atheromatous. The tension of the vessels is very high. This is due not only to the deposit of calcareous matter, but also to hypertrophic thickening of the muscular layer in the walls of the vessels. Observe the expression of the face. The lips are bluish and the face is more or less swollen, and there is some difficulty in breathing. Examination of the heart shows that there is more or less atheromatous degeneration of its valves. Notwithstanding the fact that there is no distinct lesion of the lungs, she has at all times difficult breathing. This is not an ordinary case of asthma. There is also a peculiar cough. There is no reason to suspect hepatic derangement.

Examining the urine, we find that it contains albumen. The specific gravity of the urine is low, the amount of solids excreted small, and the quantity diminished. There is general *œdema*. There are uræmic asthma, and also headache and other symptoms indicating uræmia. Such is the morbid complexus. The patient has a well-marked eruption on the left chest and mamma. This has a peculiar appearance, and makes me suspect specific disease. There are also cicatrices about the mouth, which have the appearance of having been healed under the action of iodide of potassium. In other words, the kidney lesion is probably of specific origin.

Such being the conclusion, the treatment necessarily follows. As, in all probability, there has been no thorough specific treatment, we shall begin with the green iodide of mercury, in one-eighth of a grain dose, four times a day. If this acts on the bowels, a little opium will be combined with it.

Something must be done to relieve the suffering organ by derivation, either by purgatives or diaphoretics. We shall act upon the bowels in the present instance with compound jalap powder, in drachm doses, every morning. This has an effect, by reflex action, to increase the flow of urine. If this is not enough, pilocarpin, in sufficient amount to act energetically on the skin, will then be given.

#### INTERSTITIAL NEPHRITIS.

Here is another disease of the same kind, but of a different origin. This woman has not the expression of ill health seen in the other. She is not so pale, notwithstanding the fact that her urine contains a larger amount of albumen. The first woman has been made prematurely old by the specific trouble and the remedies used to relieve it. This patient has general *œdema*, which, however, is not considerable. The feet are swollen at night and the face is puffy. There is no change in the heart

or vessels, and apparently no alteration in the liver. This is a case of simple albuminuria, but, in order to say what its real nature is, a careful examination of the urinary secretion and a microscopical examination of its sediment will be required. This we have not yet had time to do. The probability is that, as the urine is of low specific gravity, and not diminished in amount, it is a case of interstitial nephritis, and not merely a croupous condition. It is essentially chronic in its course.

As regards the remedies, I shall apply here two which I have found very successful, and which I have repeatedly recommended. These are nitro-glycerine and the chloride of gold and sodium. The latter has the property of checking hyperplasia of connective tissue. The nitro-glycerine has been found by experiment to diminish decidedly the amount of albumen; it lessens congestion and limits the change going on in the kidney. Although nitro-glycerine causes dilatation of the peripheral vessels, it is still true that it relieves congestion. The area of dilated vessels in the kidneys is small as compared with the capillaries of the body, so that the mechanical result of dilatation of the arteries in general must be to relieve congestion of important organs.

This patient will begin with one drop of the centesimal solution of nitro-glycerine, three times a day, and one-twentieth of a grain of chloride of gold and sodium in combination with a simple bitter, as extract of *nux vomica*. Under this treatment decided improvement should be observed.

#### SPECIFIC DISEASE OF THE SPINAL CORD.

Here is another interesting case, but, as my time has almost expired, I shall have to go over it very rapidly. You notice the peculiar manner in which he stands when his eyes are closed. It is with difficulty that he can cross one leg over the other. The patellar reflex on the right side is well marked; on the left it is not quite so distinct. He has some pain in the calves of the legs. These first appeared ten weeks ago. He has never had any trouble in vision, and has never had double vision. The trouble in walking has developed within a year. He has nocturnal emissions. There is lessened sensation in the bottoms of the feet.

Now what is the explanation of the rapid development of this case, for these are in large part the symptoms of posterior spinal sclerosis? It has not been evolved in the ordinary manner. The symptoms have developed in an irregular way within the past twelve months. There must be some explanation of the rapid evolution of these symptoms and of their irregularity. This, I think, we find in the condition of the tongue. You see the characteristic mucous patches. In other words, this is a case of specific disease of the spinal cord.

As the spinal cord is in danger, it will be well to use mercurial inunctions in combination with the

internal administration of the green iodide, one-sixth of a grain of which, with one-fourth of a grain of the extract of belladonna, will be given three times a day. A little opium will be added if it is necessary. One drachm of mercurial ointment will be rubbed into the groins and inner side of the thighs every day, attention being paid to the condition of the mouth, as it is important to avoid salivation, for these cases do better if the mercurial impression is not carried so far.—*Col. and Clin. Record.*

#### ABDOMINAL SECTION IN DISEASE OF THE UTERUS.

Abstract of a lecture delivered at the Jefferson Medical College Hospital, September 15, 1884 by Lawson Tait F.R.C.S.

##### OVARIAN TUMOR.

Here is a patient who, as far as I can see, is the victim of a disease which is very common with us and I suppose as common with you. At first sight, it looks like an ovarian tumor. The first thing which attracts my attention is a scar from a puncture, and here I see the remains of another puncture of an older date. I next notice the uniform shape of this abdomen. There is a symmetrical uniformity about this abdomen which is suspicious. When you see a perfectly uniform enlargement of the abdomen, begin by suspecting that it is not due to an ovarian tumor. The chances in such a case are greatly in favor of one of three things. In the first place, pregnancy, which you must always eliminate; in the second place, a small tumor with malignant growth and ascitic effusion, which is the most likely of the three; and, in the third place, the presence of a parovarian tumor. I next place my hand on the tumor,—and here let me give a caution. When you are dealing with abdominal disease either for the purpose of diagnosis or treatment, you cannot be too gentle in your manipulations. If at all rough in your manipulations, the first thing you do is to frighten the patient and obscure the diagnosis. The abdominal muscles will be contracted, and you will not be able to learn a great many things which it is desirable that you should learn. If in treating abdominal disease you handle the parts roughly, you run a risk of doing harm. I touch the abdomen gently and I have already learned a good many things. I learn, in the first place, that this certainly is not pregnancy, although I knew that before. I learn, in the second place, that it is not a parovarian tumor. I learn, in the third place, that it is probably a small tumor with a large amount of ascitic effusion. I feel in the lower part of the abdomen a semi-solid mass, and above this a mass which is not solid. Our business is to

determine what relation the mass not solid bears to the mass which is solid. Above, we obtain on percussion the resonance of the intestine. There is a matter here which obscures the diagnosis. That is the fact she has been tapped. I get an intestinal note above, and there is evident fluctuation, but from these two factors I cannot positively determine which one of the two conditions is present, and it is a rather important thing to know which we have before giving advice.

The conditions to which we refer are the following: This may be a large cyst which has been emptied by tapping, or it may be merely ascitic fluid. If it is a large cyst which has been partially emptied, or which having been emptied, has become partially refilled, it is a case of multicystic cystoma, which can be dealt with in a satisfactory manner. In the second place, it may be a small cyst covered with a large effusion of ascitic fluid. If this be the case, it will be necessary to engage in the discussion of a number of points before making up our mind. I have looked at the patient's face but find nothing there to guide me. I have examined the pelvis, but I find nothing but negative indications. The uterus is small and tolerably free. On the left side there is a small tumor which may be one of two things, either the left ovary in a state of incipient enlargement, or a small mass of papilloma. This may be a single ovarian tumor and the condition here may be the result of malignant proliferation on the outside of the tumor, or on the parietal peritoneum, or the peritoneal coat of the viscera. It is important to know which of these is the more likely. With a half-full abdomen like this, one cannot pretend to give an opinion. The fluid has been removed and reaccumulation is taking place. Although it is impossible to give a positive opinion, I have a suspicion that the fluid which was removed was not removed from a cyst. There is a small tumor in the lower part of the abdomen, and I think that the fluid which was removed was ascitic and that there is here a condition of papilloma. Suppose it is impossible to come to an exact conclusion, what ought to be done? Open the abdomen in either case; for, unless you are absolutely certain that the disease is incurable, it is, in my judgement, a surgical crime to allow a patient to go to the grave with an abdominal tumor, without an effort being made to save her. This should be done even when papilloma, which is a most unfavorable condition, is suspected.

As soon as an ovarian tumor is recognized, you should refrain altogether from tapping, and immediately remove the tumor. The patient whom we have had before us has been tapped. I do not know whether the fluid removed was ascitic or from a large cyst. My suspicion is, as I have already said, that the fluid was ascitic. At this point some critics might ask "What do you make of

those cases in which tapping was done over and over under the old practice, and sometimes under the new, for some patients will not submit to the radical operation?" In regard to the latter point, there is no difficulty with that now. During the last five or six years I have not had a patient come to me with an ovarian tumor, who has refused to have it removed. I can assure her that the chances are 98 out of 100 that she will get well, no matter what the age, no matter what the appearance of the tumor, and no matter what complication may be present, provided it is not malignant disease and that there has been no previous tapping.

Suppose you get an ovarian tumor, when should it be removed? The arguments are all in favor of early operation. The patient is not distressed with the suffering entailed by carrying around a large mass; she is not subjected to the likelihood of the development of papilloma which we suspect in this case; she is not subjected to the anxiety and worry, especially if unmarried, which her appearance will always cause, and the incision will be shorter than when the abdomen is large. The mortality of early operations is almost *nil*. If the tumor be removed before adhesions form or other complications occur, I believe that the mortality would be absolutely *nil*. My own experience leads me to believe that if the practice were uniform all over the world of removing ovarian tumors as soon as discovered, the mortality would not be one per cent. Suppose that we are certain that this patient was suffering from papilloma, that the disease of which we are so much afraid was developing around the tumor; even if I were certain that such was the case, and I were responsible for the treatment of this patient, I should proceed to the removal of the tumor. The reason for that is a very curious one, and one which I cannot pretend to explain, but the facts of which I am quite certain. I cannot say, without referring to my class-books, how many ovarian tumors I have removed, but in a considerable percentage both of parovarian and ovarian tumors, and also cases of myoma, and also in cases where there has been no tumor at all, I have opened the abdomen, sometimes knowing what I should find and at other times not knowing, and have found this curious velvety, warty condition of the peritoneum. One of the most extraordinary cases which I have ever met with, was one sent to me by Mr. Oliver Pemberton, of Birmingham, whose name is probably familiar to many of you. In this case there was enlargement of the abdomen, supposed by several who had examined her to be a parovarian tumor. As soon as I placed my hands upon the abdomen I was certain there was no tumor, but simply an enormous effusion of ascitic fluid. In such cases as this I never tap, I always make an opening in the abdominal wall large enough to admit the introduc-

tion of two fingers, and obtain an intelligent idea of the condition of the abdomen, which cannot be obtained by gazing at the fluid falling from the end of a canula. There is no more danger in this than in tapping. So far as my own practice is concerned, tapping is absolutely discarded. In the case to which I have referred, I made the abdominal opening, and slipped in two fingers, and at once found that I had to deal with universal papilloma of the peritoneum. I inserted a drainage-tube, and allowed it to remain two or three weeks, and completely cured the patient. She is now in robust health some four years after the operation. In another case, in a woman fifty-seven years of age, I removed a large ovarian tumor. Large masses of papilloma were also found. Two of these, each being larger than the fist, could not be removed, and after the operation could be distinctly felt through the abdominal wall. She is now sixty-five years old in good health, and the tumors have disappeared. It is certain there are two kinds of papilloma, one of which is malignant, and which will kill the patient in a few weeks or months, and another kind which is not malignant, and can be cured by removing the tumor or by opening and draining the cavity. I have submitted pieces of papilloma, some of which were obtained from cases which had been cured, while others had come from cases rapidly fatal, to the most experienced microscopists, and they have been unable to detect any difference between the two varieties. This curious condition, presenting as it does such extremely different features, so far as results are concerned, offers a very favorable field for careful research by pathologists. In this case, even if I knew positively that there was present an ovarian tumor complicated with ascitic fluid and large papilloma, I should still urge that if it is possible to remove the tumor, it should be done, for there is a chance that the patient will be cured.

#### REMOVAL OF THE UTERINE APPENDAGES.

The next case is one which would involve a great deal of talking, and one of which I cannot speak anything like exactly, for that would involve an intimate knowledge of the past history of the patient. For the purposes of instruction however, I may assume what is doubtless the fact, that this girl's sufferings are real and intense, and that everything short of surgical interference has been employed. I might with advantage talk of a case which I treated in the state of New York, in which the condition was to some extent similar to that of the present case, and in which the history was more completely known. For that matter, a supposititious case might be discussed, for it would be easy to introduce into it those questions which are worthy of notice. This is all the more advisable because we have the tracks of very well cleared abdominal surgery on almost all points

which are under discussion with the exception of one. The patient who has been admitted to me comes under this category. She is twenty-one years of age and has a pronounced crop of acne all over her face. When a woman enters my consulting-room, and I see acne, I always ask if she has been taking bromide of potassium. This is the fashionable drug for every conceivable uterine ailment, and yet I have never heard of any one who was willing to swear that he had ever cured anything with bromide of potassium that was worth curing. Still it is the one pump handle which we have, and we work it pretty hard.

How do you recognize the fact that a patient's sufferings are real? I cannot answer that question. All that I can say is, that never in my experience have I had a woman submit to an operation, without sufficient cause to justify it. Of course, I, as all ought to do, place my statement and views, with what I propose to do and the results of the operation, immediate and prospective, clearly before the patient, and, as I say I have never known a woman to submit herself to the operation without finding sufficient cause to justify its being done. You say this puts the responsibility on the patient. Well, that is what we do in every case. The patient cannot be relieved of all responsibility. A man comes to you with a diseased knee-joint. You lay before him the advantages and disadvantages of excision and of amputation, and then you ask him, "Will you have your limb amputated, or will you run the risks of excision?"

This girl is twenty-one years of age; she has to make her own living, and this is a very important matter, indeed. If a woman comes to you whose husband has a large income, or whose friends are wealthy, the case presents altogether a different aspect. To the rich, luxury always contributes largely to the relief of pain. If a woman, whose husband has ten thousand a year, has a chronic inflammation of the ovaries, she will suffer far less than a woman who has to make her own living and has the same disease. If a woman comes to you stating that for one week out of every four she is unable to work, you are bound to perform an operation for her relief. This girl has gone through a long course of treatment. She suffers at her periods, but at other times is tolerably well. The indications for treatment are clear. If a woman tells you that there is one week out of every four that she cannot work, it is clear that the arrest of menstruation will afford relief. As far as I can judge from the history of this patient, the operation which has been suggested is justifiable. You perform the operation, and what do you find? I have always found disease of the uterus or uterine appendages of some kind. These diseases are far more numerous than you imagine, and it would take a long series of lectures to discuss them thoroughly. On the left side, in this girl, there is



a feeling as though there was a mass. I think that, in all probability, it would be found that the ovaries, like the uterus, are infantile in size and probably adherent. Suppose however, that the appendages turn out to be absolutely healthy; I should still say that the operation was capable of being justified by the history of the case.

What are the results? In the great majority of cases there is an immediate relief from suffering and loss of blood. In some cases the relief does not come immediately; but after a time, in a few cases, relief may not come at all; but this is no argument against the operation, any more than it is against many other operations. Take the operation of cataract. This is not always a success. It is probable that in about ten per cent. of all operations for cataract, suppuration of the globe takes place, and the result may rank as mortality. In other cases escape of the vitreous or some damage to another structure will result in such chronic inflammatory change as to leave the consequential results of the operation so bad that it may be classed as a complete failure. There is no realm of surgery out of which I could not pick abundant illustrations to show that in no other branch is success any greater, if as great, as in that of which I have spoken. Immediately after the operation the patient suffers from the climacteric; but this is inevitable in the life-history of every woman who lives to the age of fifty-two. I do not think that these women, who go through these troubles in early life, suffer any more, or even as much, as those in whom it comes at the natural time. Some do not suffer much, while others suffer a great deal.

So far we have not had any trouble, except from one thing, and this is a distressing one. It occurs after all sorts of abdominal operations, after exploratory incisions, after the removal of one ovary for cystoma, after the removal of both ovaries for cystoma, and after hysterectomy. I refer to the occurrence of acute melancholia. All the cases of mental alienation that I have seen following these operations are seven in number, and all have taken the direction of this most unfavorable form of insanity—acute melancholia. I cannot say that any one of them is likely to recover. I do not know that this is a necessary result in a certain number of cases. I have performed abdominal section some 960 times, and in this number I have met with 7 cases of acute melancholia. Of course, a good many of these cases died, especially in the earlier years of my practice. We may state that acute melancholia occurs in about one per cent. of those submitted to abdominal section. I do not know that anything like this follows other surgical operations. This is the only after-result of an objectionable character with which I am acquainted.

#### MYOMA OF THE UTERUS.

The next subject which Dr. Parvin has submitted for consideration is that of myoma of the uterus. There are two patients outside, but I do not think that it is necessary to bring them in, for you cannot see anything, and you cannot feel anything. I have examined the patients in the waiting-room. One woman is forty-eight years of age, and does not suffer much from hemorrhage or very much in any way. The tumor is hard, shrivelled, and solid, and thus it is placed in the category of cases in which nature has cured the disease. In all probability, nature will not remove the tumor, but nature has relieved the symptoms and so diminished the size of the tumor by shrinkage that nothing more will be required. The other patient is forty years of age. She has had only two hemorrhages, and it is very likely that she can be tided over the climacteric without any surgical interference. Usually, we do not operate on women for fibroma after the age of forty-six or forty-seven unless it is perfectly clear that the use of ergot combined with absolute rest is insufficient to tide her over the climacteric. When, however, the disease appears in young women, say from thirty-five to forty, or as I have seen it in a girl of nineteen, an important question comes up for careful discussion, and here again the patient must accept a good deal of responsibility in the answer. If a patient spends one week of every month in bleeding and suffering pain, becoming anæmic, restless, and irritable, unable to look after her affairs, and you cannot relieve the sufferings or arrest the hemorrhage except by operation, then this question must be considered. Is it worth while for that patient to go on suffering for a series of years when by an operation, the mortality of which is only four or five per cent., she could be relieved? On this point different men will express different opinions. If I were the patient, I should have the operation done. Holding that opinion, I advise the patient to have the operation performed.

Concerning myoma of the uterus, we have a number of traditions which are being rapidly destroyed. One tradition is that myoma is not a serious thing. We have been in the habit of finding, at our post-mortem examinations, a large number of myomata which have never given any trouble, but I need not say that the tumors which do not give rise to trouble, are not the ones which trouble us. The tumors which cause trouble are the ones which we see. If a tumor gives rise to hemorrhage and pain, the woman consults a physician, who recognizes its presence.

There is another tradition, that the occurrence of the climacteric arrests the growth of the uterine myomata. It is now perfectly clear that a certain class of uterine myoma arrests the progress of the climacteric. Frequently we find women going on for years after the usual time of the climacteric,



without any appearance of diminution in the size of the tumor, or in any amount of the hemorrhage. There is a peculiar kind of uterine myoma which causes but little pain or hemorrhage, but which goes on indefinitely increasing in size, and seems to be unaffected by the climacteric.

In uterine myoma, provided the use of ergot and rest does not give relief, one of two procedures may be adopted. The uterine appendages may be removed and menstruation, which seems to be the immediate process by which the growth is encouraged, arrested. It is a fact established beyond discussion that in the great majority of cases operated on hemorrhage is immediately arrested, and the tumor shrivels up, and may disappear. The removal of the uterine appendages is an operation to be recommended in a certain class of cases. In some cases in which the disease is not arrested by the removal of the uterine appendages, there is the far more dangerous operation of removal of the entire uterus or hysterectomy.—*Med. News.*

**TUMORS OF THE BLADDER; CYSTOTOMY.**—Dr. J. L. Little (N. Y. Surg. Society) presented a number of tumors which he had removed from the bladder of a patient in St. Luke's Hospital, who gave the following history, which was kindly furnished by Dr. Ludlow of the house staff: "James McA., aged forty-nine, married, a car-driver by occupation, and a native of Ireland. His family history is good. About eight years ago he had a sudden hæmorrhage from the bladder while urinating. For two days previous he had micturition and pain at the symphysis pubis. From this time up to one year ago the hæmorrhages recurred at intervals of three or four months, and lasted about as many days. During all this time micturition was not very frequent, and he continued at work. About one year ago the quantity of urine voided steadily diminished for about one week, and then stopped altogether, and it was necessary to resort to catheterization. Since this time he has constantly used the catheter, as he has been unable at any time to pass more than a small quantity of urine, and that with great pain. The desire to urinate has become more frequent. The patient was sent to Dr. Little's clinic at the post-graduate school, by Dr. W. B. Wallace, about two months ago. "On examination, no calculus was found, and it was discovered that the introduction of a sound or a soft catheter was always followed by a fresh hæmorrhage into the bladder. He was able to hold his urine without pain for six or eight hours at a time. The symptoms indicating a growth in the bladder, he was sent to St. Luke's Hospital for an exploratory operation. A consultation was held and the operation advised. An examination of the urine showed pus, blood, mucus and triple phosphates. No casts or shreds of tumor were found.

"On October 27th Dr. Little performed median cystotomy. On introducing the finger, a number of soft tumors could be detected. These were situated at the trigone of the bladder, between, and extending beyond, the orifices of ureters. A number could also be felt attached to the upper surface of the bladder. The situation of these growths being distinctly made out by the finger, Thompson's tumor forceps was introduced, and the tumors were seized and twisted or bitten off from their attachments. It was found necessary to enlarge the opening in the bladder by a slight incision downward toward the prostate in order to introduce the forceps with facility. Twenty distinct masses, most of them seeming to be separate tumors, were removed. These varied from the size of a hazel-nut to that of a hickory-nut. They all seemed to be villous in character. A large number of small pieces, evidently torn off from the larger tumors, were also removed. The surface of the bladder, after the removal of these growths, was left considerably roughened. Two orifices, large enough to allow of the introduction of the tip of the finger, could be felt in the situation of the openings of the ureters. These seemed to be the dilated orifices of the ureters. The hæmorrhage during the operation was considerable, but not enough to be alarming at any time. After the operation was completed, the bladder was thoroughly washed out with hot boro-salicylic acid solution. This seemed to greatly lessen the hæmorrhage. The wound was left open, no tube or catheter being used. During the evening following the operation the hæmorrhage was very free at times. Dr. Hance, the house surgeon, tried injecting a solution of tannic acid without effect; finally he succeeded in controlling the hæmorrhage by packing the rectum with ice, and applying ice-bags over the pubes.

"October 28th.—Patient's condition is good. Temperature 99° F., urine stained with blood." Since the last notes in the history furnished by Dr. Ludlow, and read the society, the patient had been steadily improving, passing all his urine from the penis without pain, free from hæmorrhage, and without recourse to a catheter. The microscopic examination, of the tumor would be reported at the next meeting.—*N. Y. Med. Journal.*

**FOREIGN BODIES IN THE EYE.**—Dr. Agnew, of New York, writes;—*Am. Prac.*—"When a patient comes to you complaining of a sensation as if a foreign body were in the eye, you first examine the eyeball from every point of view. You should then turn over the eyelids and examine their inner surface. And here I am reminded of a source of error to which I would call your attention. A few days ago a case came under my observation which illustrates the point. The gentleman had had occasional attacks of conjunctivitis for a year or more. He had then a sensation as if a foreign

body were in the eye. On turning out the right lower eyelid, all that was revealed to sight was a slight redness of the conjunctiva. But there was something in the way in which the sensation of a foreign body in the eye was exaggerated that made me suspect he had a single inverted eyelash. Ordinarily he felt as if some irritant was there which was tolerable, but suddenly there would be a cramp-like action of the eyelid, the irritation would grow rapidly worse, and the eye would fill with tears, followed by the discharge of a little mucus, and temporary relief. His beard was of a sandy color, his hair was light brown, and his eyelashes were almost colorless. I looked very carefully along the edges of the lids in search of inverted eyelashes, and saw, on the innermost edge of the lower lid, a slight curving of the inner angle. By allowing a tear to gather upon this inner edge, I saw there was a difference in refraction in different portions of the tear, and it soon became evident that a delicate decolorised eyelash was there, which, instead of growing from the outer edge of the lid, sprang from the free edge of its inner border. I turned the lid over, and found that this delicate eyelash, which was between the edge of the lid and the eyeball, had been so long caught in that position that it had worn a little groove in the edge of the eyelid; the spasmodic action of the orbicularis, from time to time, so long continued, had embedded the eyelash in the substance of the lid. I removed it, and no further trouble was experienced. This patient had been treated in Europe for acute conjunctivitis several times, and it is possible that the eyelash was on those occasions the cause of all the trouble. An operation will be required to destroy the follicle which produced the misplaced eyelash. So, when a patient comes to you complaining of a sensation as though there were a foreign body in the eye, between the eyelids and the eyeball, you must first look for conjunctivitis. Whether this be present or not, you should then proceed to examine the eye very carefully to see whether a foreign body be present or not. Scan carefully the whole surface of the cornea and of the scleral conjunctiva, and then turn over the upper eyelid and carefully inspect its inner surface. You may then scrutinize the edges of the lids, as I have described, in order to see whether the source of the irritation be an inverted eyelash."

COMBINED VERSION IN PLACENTA PRÆVIA.—C. Behm (*Med. News*, Aug. 16, 1884) has used combined version in forty cases of placenta prævia, without a single death. This must be regarded as an extraordinarily good result for a condition which ordinarily gives a mortality of forty per cent. Hofmeier has already obtained similar results in the treatment of placenta prævia.

The operation is performed as follows: When dangerous hæmorrhage comes on the vagina should

be tamponed until the cervix is dilated. This being done, and the woman anæsthetised, the whole hand is introduced into the vagina, and two fingers into the cervix. If the membranes present, the operator endeavors to rupture them with the finger, then draws the presenting part (unless it be the buttocks) to one side, at the same time making pressure from without so as to carry the buttocks down until he can grasp a foot. This is drawn through the cervix, so that the breech acts as a tampon on the lower segment of the uterus, and the placenta is pressed against the sides of the uterus. In central implantation of the placenta the finger should be pushed through the centre.

After this version the operator waits for the spontaneous expulsion of the child, or at least complete spontaneous dilatation of the cervix, in order to complete delivery. The duration of labor after version is between one half an hour and eleven hours, the average being one or two hours.

The mortality for the children by this procedure is very great, but the chances for the mother are better. The mortality for the children is, however, no greater than by the old operation.

The causes of the great mortality of the mother under the use of the continuous tamponade is the infection through the blood and other matters adhering to the tampon.

THE USE AND ABUSE OF THE FORCEPS.—Professor Goodell made the following remarks in a recent clinical lecture (*Med. and Surg. Reporter*, June 14th): Tears of the perinæum will occur whether the physician uses the forceps or not, but in the majority of cases they come from the use of the forceps, or rather from the abuse of the forceps. Let me give a piece of advice to you as young men. When the proper time comes put on the forceps and boldly bring down the head, but when it begins to bulge the perinæum, take off the forceps. I do not think that any of you are competent to deliver the head over the perinæum with forceps. The temptation is to turn the head out too quickly. If you take off the forceps you will rarely have a bad tear, and if it does occur you will not get the blame for it. It is a very rare thing for me to end a labor with the forceps on. When the perinæum begins to bulge, I support the handles to see whether the pains are strong enough to end the labor. If so, I remove the forceps. There is such an abuse of this instrument that I sometimes think that Baudelocque was right when he said that the forceps had done more harm than good. It requires great skill and judgment to end a labor with the forceps. A physician from inexperience, or being demoralized by a long and tedious labor, is liable to use undue violence and deliver the head too quickly, or to make a traction in the wrong direction. I have myself torn the perinæum and seen many good physicians do the same. From this experience

I should recommend that, unless their be an excellent reason for contrary action, the forceps be taken off when the head reaches the perinæum. Occasionally one blade will catch over an ear and you cannot get it off; but in the majority of cases it can be removed, and that is the proper thing to do.

**PRESERVATION OF BODIES FOR DISSECTION.**—O. T. Freer writes from Munich that, in the anatomical department of the University, the material used for dissection seems to keep fresh much longer than he has found to be the case in the medical colleges. He learned from Prof. Rudinger that the injecting fluid used in the preparation of the bodies is a mixture of carbolic acid, glycerine and alcohol, and this method has been in use since 1882. Subjects injected with this mixture will keep fresh from two to six months, according to the quantity of injection used. For preserving bodies three to six months, the solution is composed of glycerine, 40 parts; carbolic acid, crystalized, 11; alcohol, 8. For preserving them two to three months, glycerine, 80 parts; carbolic acid, 17; alcohol, 13. The injection is made into the femoral artery, and the amount used is two to four litres, or quarts, though an ordinary subject will readily contain fifty per cent. more than the larger quantity.—*Chic. Med. Jour. and Ex.*, July, 1884.

**CHRONIC NASAL CATARRH.**—Dr. M. M. Brown, M.D. of Ithaca, N. Y. (*Med. Summary*) gives the following treatment for chronic nasal catarrh—where hard scabs are formed.

R	Acid carbolic,	gtts. xv,
	Potass permang.,	grs. v,
	Aqua.	3 ij,
	Glycerine, q. s. ad.,	3 ij M

To be applied to nostrils in the following manner with a camel's hair brush, nightly. Saturate a long camel's hair brush in a sufficient quantity of the fluid, push the brush well into the nostrils after having blown the passages clear of crusts, allow the brush to remain for five minutes in each nostril, or until the preparation can be tasted in the fauces. Repeat this until all signs of disease have disappeared. Constitutional remedies should also be used, such as iodine, iodide of potass, in syrup of ginger, etc. Dyspepsia and mal-assimilation of the ingestæ should be corrected in every case. When there is much discharge of an offensive nature, mingled oftentimes with bloody matter dropping into the fauces after meals and on getting up from bed, I apply the following powder once a day to the fauces and nasal passages with an insufflator:

R	Potass permang.,	grs. x,
	Talc	3 j,
	Bismuth Subnit.,	3 j.
	Hydrarg. chlor. corrosiv.,	grs. ij. M.
	Ft. in pulv.	

Ten grains of this powder blown upon the diseased surface behind the velum and into the anterior nares every evening works like a charm. Prepare the powder carefully. Still another formula, when the fetor is intense:

R	Iodoform,	
	Calomel,	
	Bismuth subnit.,	aa 3 j,
	Talc,	3 ij. M.
	Ft. in pulv.	

I prefer this powder to the first named in nearly all cases. For chronic sore throat I use the following solution:

R	Hydrarg chlor. corrosiv.,	grs. ij,
	Alcohol,	3 ij,
	Aqua q. s. ad.,	3 ij. M.

Apply with camel's hair brush to the enlarged follicles two or three times a week. If smarting is intense mitigate it with glycerine or a little vaseline.

**PRURITUS VULVÆ.**—Itching of the external genitalia is one of the most prevalent and tormenting conditions with which a woman can be afflicted. Hence, any remedy that will palliate this disorder is gratefully received by both patient and physician.

Dr. C. J. Smith of New York says:—The following formula has, in my hands, given relief when nothing else has been of the slightest benefit:

R	Ext. geranii mas. fluid,	gtts. xx,
	Ext. belladonæ fluid,	gtts. iij,
	Zinc. sulph.,	gr. j.
	Vaseline,	3. j M.

Sig.—For external application.

If the parts are not much inflamed I usually omit the belladonna. I have prescribed this in many cases, and with few exceptions, it has afforded immediate, and, in some instances, permanent relief. I have found it of value in pruritus ani.—*Medical Advocate*.

**STRANGULATED HERNIA.**—The *British Medical Journal* gives us the following points on the diagnosis of strangulated hernia. Dr. Englisch, of Vienna, on examining the urine of patients under treatment for strangulated hernia, has ascertained that it always presents albumen in proportion to the duration of the strangulation. If surgical means be not adopted, the albuminuria continues until the death of the patient. The quantity of albumen is not affected either by the date of the hernia, the size of the sac, the frequency of the anterior strangulations, nor by a febrile condition. When there is simple protrusion of the omentum, albumen is absent. Prof. Nothnagel attributes this albuminuria to diminished intravascular pressure resulting from the presence of a strangulated hernia.

—*Kansas City Medical Record*.

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*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## THE PHYSICIANS OF THE FUTURE.

Physicians and Surgeons in the British Isles, we are aware, are averse to specialism. Even those who pre-eminently excel in the treatment of particular classes of diseases, strive, by avoiding the habit of devoting themselves to these single classes, to set an example of a general rather than a limited practice. Despite this tendency, however, we cannot but think that specialism is the feature of the age. As the population increases, the amount of labour and competition proportionately increases. The result is that the law of the division of labour is now carried to its extreme limits. Nor is this law confined by any means to manual labour; intellectual labour comes equally under its operation. In short, specialism in every form is the salient characteristic of the nineteenth century. Grant Allen, in an article in the *Nineteenth Century* some months ago, very wittily pointed this out in an imaginary dialogue in which an Oxford graduate, despairing of fame in a life devoted to Greek, or Latin, or even Hebrew, Chaldee, or Syriac, vowed that he was "going in for the Ostiak dialect of Tungusian." The richness of the joke is only apparent when it is known that the Tungusks are an obscure little tribe of fishermen living on the almost unknown banks of the Yenisei, and that the Ostiak dialect is a corruption of their language by a yet more obscure neighbouring tribe.

In the science and practice of medicine and surgery specialism certainly is a most marked fea-

ture. Should it continue to increase at the same pace as it has done for some years past, it is no uninteresting and certainly no unimportant task to see where it will eventually land the profession. And indeed, the consideration of this subject is almost a duty. The young practitioner, and especially the student, must look ahead and endeavour to foretell, and to adjust his methods to the profession as it will be, when he hopes to be in its front ranks.

What, in broad outline, has been the history of specialism during the lifetime of the medical man who was "capped," say fifty years ago? The first step in this direction was, probably, the separation of wards in a hospital for distinct diseases. Then followed entire hospitals devoted to a single class of diseases. These gave opportunities for special study, and from these arose the famed specialists of to-day. The effect of this upon the profession at large is, that the class of cases treated by the general practitioner—and by general practitioner we do not refer to those who, as Bacon says, "take all knowledge to be their province," the "physician, surgeon and accoucheur"—will gradually become more and more limited. A patient has ear-ache; he calls in a general practitioner, who prescribes morphine. The effects of the morphine wear off, the ear-ache returns. He then goes to an aurist. The aurist diagnoses catarrh of the middle ear, punctures the membrana tympani, and cures the ear-ache. Any medical man could multiply such instances a hundred fold. And it is instances like this, daily occurring, that will soon teach the public to forsake the "family doctor" and resort to the "eye, ear, throat, lung, and nose doctor." The family doctor will soon be an institution of the past, and his place will be taken by a circle of doctors. Materfamilias will go to her gynecologist; paterfamilias probably to the whole round, according as he imagines it is his liver, or his heart, or his lungs, or his spleen that is affected.

We are by no means treating the subject lightly. But to come to a sober view of the case, and seriously to conjecture, on scientific principles, what will be the character of the physicians of the future. We think we shall express the opinion of the majority of the faculty in the following prophecy:—First, there undoubtedly will be men who by their fame as diagnosticians will be resorted to on the first appearance of any malady. Finding his forte

lies solely in diagnosis, and finding it impossible to be thoroughly *au fait* in other branches, *e. g.*, therapeutics, treatment, posology, etc., in the then enormously wide areas that these will cover (we speak, say of fifty years from now), the diagnostician will hand his patient over to the specialist for the lungs, liver, stomach, nervous system, and so on, just as now the ordinary practitioner hands him over to the oculist or aurist. These will in turn hand him over to the therapist with minute directions as to the effects he wishes to be produced upon the system and the tissues. Still more in the future, probably, there will be classes of diagnosticians and therapists. This is no visionary theory; the germs of such a system exist all around us if we will but recognize them. The same process is obtaining in kindred sciences; for example, in biology there are men who not only devote themselves entirely to one of the two great branches into which it is divided, morphological and functional biology, but go so far as to give themselves up to the study of one minute part of the many divisions into which each of these is broken up—as myological or osteological development, etc.

If then, we are not altogether incorrect in our surmise, the lesson for the student is that if specialism is the tendency of the day, and the all-in-all of the near future, to specialism he must devote himself—with this caution: that no specialism is possible except that which is built upon the broad foundation of a thorough knowledge of anatomy, physiology, chemistry, etc., etc.

#### THE ANNUAL MEDICAL BANQUETS.

The occurrence of the annual dinners of the graduates, under-graduates and professors of the various medical schools is looked forward to with much interest and pleasure. These occasions are made the opportunity of eliciting the expression of opinion of competent persons on matters connected with education generally, and medical education in particular. That this is recognized by the students themselves is evident from the large number of complimentary tickets issued, and also by the prominence given to those toasts which call forth speeches from eminent educationists and politicians. The banquets this year have been no exception in this respect, and we have been treated

to some very valuable remarks by those best qualified, both from ability and experience to express an opinion. These banquets, according to the custom of the medical dinners for many years, were conducted on strictly temperance principles, and the toasts were drunk in cold water.

The annual banquet of the Toronto School of Medicine was held on the 12th ult., and was well attended. The chair was occupied by Dr. H. Bascom, supported on his right by the Lieut.-Governor of Ontario and Dr. McVicar, and on his left by Mayor Boswell, Prof. Clarke, and others. After justice had been done to the good things provided for the occasion, toast, song and sentiment followed each other in rapid succession, until far into the evening. The Lieut.-Governor in his speech, which was witty and well received, alluded to the obligation which the schools were under to the Hospital, and also gave a short sketch of the history of that institution. Prof. Clarke, of Trinity College, in responding for the "Universities and Colleges," said that in spite of expressions to the contrary there was the best possible feeling between the several universities in Canada. A scheme for the federation of the different universities is now very widely talked about, and he hoped that some such scheme would be effected so that a common standard might be obtained which would ensure degrees of fixed worth. He thought that while a multiplication of colleges was good, a multiplication of universities was an evil. He referred to Dr. Wilson's recent letter in defence of University College, and wished that Dr. Wilson had been more specific in his references to the persons who had made the charges which he combats. He hardly thought that Dr. Wilson placed Trinity University among the number, for Trinity was a non-sectarian university. Prof. Ramsay Wright responded for University College, and Principal Buchan, for Upper Canada College. The "Dominion and Local Legislatures" was responded to by H. E. Clarke, M.P.P. The "Learned Professions," "Graduates and Graduating Class," "General Hospital," "Freshmen," "Ladies," and the "Press," concluded the list of toasts, and a very pleasant evening's entertainment was brought to a close.

The Trinity Medical College banquet took place on the 20th ult., and was very largely attended. The chair was occupied by Mr. P. A. Dewar, sup-

ported on his right by Lieut.-Governor Robinson, Hon. Senator Allan, and Provost Body, and on his left by Hon. Edward Blake, Mayor Boswell, Dr. Widdifield, and others. After dinner was served the sound of the bugle announced the commencement of the toasts. The chairman delivered the opening speech, and in doing so referred to the large increase in the number of Trinity students, which made it the largest medical school in Canada, and also to the honor and success which her graduates had gained in other lands. He made a humorous defence of the students against the charge that they were a noisy, reckless crew, and concluded by proposing the health of "The Queen." "The Governor-General and Lieut.-Governor of Ontario," was responded to by Lieut.-Gov. Robinson. He referred to the large number of medical students about him but said that our vast country would give wide field and scope for their talents. Every profession in Canada had to contribute its portion to the welfare of the State, and he had no doubt the medical fraternity would do its full share thereto. "The Dominion and Provincial Legislatures," was the next toast. Hon. E. Blake, who was cordially received, said he was afraid that in the ranks of the political doctors there were more quacks than among the medical profession. Some people believed that their patient—Canada—was in rather a critical condition. It was said she had been bled too freely; that there were some organic defects in the system which ought even to render an operation necessary. But he was inclined to think that she would stand a good deal of killing. The legislators of this country had serious duties to discharge in welding the various parts of this country into one nation, and creating that unity of feeling essential to make Canada the country she ought to be. To its success was essential a widely diffused education, and a widely diffused public spirit. No man in Canada made a stronger candidate for Parliament than a popular country doctor. No man had more influence, and with the influence came responsibility. The medical profession was indeed a noble one. In the strict line of duty, it was a business of blessing. After referring to the great advances made in recent years in medical science, he concluded by wishing the profession all prosperity. Senator O'Donohoe also responded.

Dr. Widdifield responded on behalf of the "Prov-

incial Legislature." He referred in feeling terms to several of his old friends on the staff of Trinity Medical College, and especially to one who was absent owing to recent family bereavement. He also said that he had had an opportunity of visiting the medical schools of the United States and Europe, and could say that the medical schools of Canada compared favorably with any he had seen. The "Mayor and Corporation" was responded to by Mayor Boswell, who told the students that if they went home singing their songs without shouting he would guarantee they would not be molested by the police. The "Universities and Sister Institutions" was responded to by Chancellor Allan, Drs. Aikins, Barrett and others; "Trinity Medical School," by Dr. Geikie, the Dean; "Toronto General Hospital," by Dr. O'Reilly; and the "College of Physicians and Surgeons, Ontario," by Dr. Morton. The "Learned Professions," "The Ladies," and the "Press," were duly honored. A number of College songs, solos and glees enlivened the proceedings.

#### ONTARIO MEDICAL ACT AMENDMENTS.

The Committee appointed by the Ontario Medical Council at its last meeting to draft certain amendments to the Ontario Medical Act, met on the 4th ult., and after discussing certain proposed amendments, had an interview with the Attorney-General and other members of the Government, with reference to the same. The Attorney-General promised to give the matter his careful consideration. The proposed amendments were published in the daily press so that we need not reproduce them here. There can be no doubt about the propriety, nay the necessity, for the enactment of some of the clauses. Others, however, are more open to question. The first provides that no College or University shall be entitled to send a representative to the Council unless it has a medical staff of teachers actively engaged in teaching. This clause seems necessary inasmuch as there is a preponderance of college representatives, out of all proportion to the number of territorial members so that in justice to all parties it became necessary either to increase the number of territorial members or lessen the number of College representatives. Another clause which it is most desirable to have placed on the statute book provides,

"That all actions brought against medical practitioners for malpractice must be instituted not later than one year from the date of such so-called malpractice, and also that security for costs in suits for damages be given by plaintiff." It is suggested in regard to the latter that a private examination might be held before a judge of the Superior Court, and if he thought it doubtful that a conviction would be obtained against the defendant he might order the plaintiff to give security for costs. We are somewhat doubtful, however, whether such a provision can be successfully carried through the House, inasmuch as it may be considered class legislation, but it is well worth the effort. The proper payment of medical witnesses in courts of law or equity constitutes another important clause which we hope to see enacted.

One very important clause referring to the internal discipline of members of the College is urgently required. It is useless for the Ontario Medical Council to proceed against unlicensed practitioners and enforce the penalties of the Act, so long as impecunious registered practitioners are permitted to prostitute their high calling by accepting salaries from the ignorant pretenders who infest the country. The following clause, taken from the British Medical Act, giving the Council power to erase or suspend the name of any one who has been "guilty of any infamous or disgraceful conduct in a professional respect," might without any difficulty be passed through the House. There appears to be considerable objection to the proposed clause relating to the annual fees payable to the Council. Many object to the payment of an annual fee of \$5, and also to the commutation life payment of \$20, less the amount already paid in annual assessment dues, claiming that it is an interference with vested rights. The main difficulty appears to arise out of the inconvenience of collecting the small annual fee of \$1 under the present working of the Act. If, therefore, the following clause were added, leaving the annual assessment as at present, the matter would be placed on a more satisfactory footing, viz.: that such fee shall be deemed to be a debt due by the member to the College, and be recoverable with costs of suit in the name of the College of Physicians and Surgeons of Ontario, in the Division Court in the City of Toronto.

EDWARD M. HOOPLE, M.D. L.R.C.P. etc.

Dr. Hoople of Atlanta, Ga., formerly of Toronto, who died on the 3rd of last month of typhoid fever complicated with hemorrhage of the bowels, was a young man of great promise. He graduated with honors in Trinity Medical College in 1883, and after obtaining the above-mentioned British qualifications, settled in Atlanta, Ga. We have received a long letter from Dr. G. G. Roy, Prof. of Materia Medica in the Southern Medical College, giving a detailed history of his illness, and speaking in the highest terms of his professional abilities, kindness of heart, and amiability of character. We regret that the letter is too long for the space at our disposal. Dr. H. was rapidly gaining the confidence of the people in his new-found southern home, and had he lived would soon have secured a lucrative practice. His family and friends have our deepest sympathy in their affliction.

GEO. W. NELSON, M.D. C.M.

The subject of this notice was resident surgeon of the Panama Canal Company's Hospital. He came of a family of doctors, being the ninth in direct descent, and the second son of the late Dr. Horace Nelson of Montreal. He graduated with honors in Bishop's Medical College in 1879, taking the final prize. After graduation he practiced a short time in Mount Forest, Ont., and then in Marbleton, Que. His health having given way he removed to a warmer climate, and being offered the appointment in the Canal Company's service he accepted it. He filled the position not only most ably, but also amassed a valuable collection of clinical notes on the fevers of the country; and a series of meteorological observations conducted by him, will throw some valuable light on the influence of atmospheric conditions on yellow fever. They will be published for the benefit of the profession, in the near future. He was a man of genial and kindly nature, frank and manly in his social relations, and much loved and respected. We tender Dr. Wolfred Nelson, and the other members of the family, our warmest sympathy in their sorrow and loss.

EDWARD JENNINGS, M.D.

We regret to announce the death of Dr. Edward



Jennings, of Halifax, N.S., at the age of 68 years. He graduated in 1843, and was probably one of the best known physicians in that city. Although brusque in manner, few men were more kindly disposed or did more charity work than Dr. Jennings. He was coroner for many years, and his position gave him opportunities of doing good which he availed himself of in endeavoring to bring about reforms in the social and sanitary condition of his fellow-citizens. His death will be deeply regretted by a large circle of acquaintances.

GEORGE WILLCOCK, M. D., L.R.C.P., ED.

The sudden and unexpected death of Dr. Willcock of this city, in the prime of active professional life, was a surprise to his many warm friends. He was a man of great promise, and had his life been spared a few years, he would have risen to eminence in his chosen profession. He was greatly beloved and respected, and leaves a wife (a relative of W. W. Ogden, M.D.) and one child to mourn his untimely loss.

**MURIATE OF COCAINE.**—In our last number we made a short note of this new and valuable anæsthetic. Since then it has been tried extensively in nearly all the cities of the new world, and the medical journals are filled with reports of its use, and the satisfactory nature of the results obtained. Its peculiar properties have been known to the profession for about a year, its use being to diminish sensibility in operations on the larynx. Dr. Koller first demonstrated its anæsthetic properties on the eye at the Ophthalmological Congress in Heidelberg, in September last. Since that time it has been tested by ophthalmologists in Europe and America with the most satisfactory results. Cocaine is an alkaloid obtained from the leaves of the *erythroxylon coca*. The drug is applied by instilling into (or brushing over) the part a four per cent. solution at short intervals until complete insensibility is produced, when the operation may at once be proceeded with. Reports of its use in practice by Drs. Rosebrugh and Reeve of this city will be found in another column.

**AS OTHERS SEE US.**—Prof. Struthers who visited Canada with the British Science Association, in his opening address in Aberdeen University, stated that he never heard better speaking than at the

dinner of the Canadian Medical Association in Montreal, or more evidence of culture in the profession of any country. He also spoke very highly of our preliminary and professional examinations, and the excellent character of the teaching and examinations of our Universities. In his opinion however, better endowments were required for our scientific chairs. In conclusion he said that upon the whole the medical profession in Canada deserve the best sympathy and support from Great Britain in its efforts to maintain a good standard in the face of the depressing tendencies of the system of the neighbouring States of America.

**A MATTER OF OPINION.**—We have again been favored with one of those magnificent works of art by John Rogers, 23 Union Square, New York. The following cut gives a faint idea of the design of the artist. It represents two physicians in consultation over a lady patient. One of them is ex-



amining the pulse and apparently explaining his view of the case. The other plainly shows his scorn and contempt for such a gross breach of professional etiquette and is buttoning up his coat and preparing to leave. The work must be seen to be fully appreciated. It would be most suitable as a Christmas or wedding present, or as an ornament in a doctor's office.

**OTTAWA MEDICO-CHIRURGICAL SOCIETY.**—This Society held its first meeting of the season on Fri-

day, October 31st; the President, Dr. Powell, in the chair. The Secretary's report was read, showing the affairs of the society to be prosperous. It was unanimously decided to hold the regular meetings twice a month during the coming year. The following officers were then elected:—President, Dr. J. A. Grant; Vice-Presidents, Drs. Horsey and S. Wright; Secretary-Treasurer, Dr. Grant, Jr.

At the regular meeting, November 14th, the President delivered the annual address, which will appear in our next issue. At the next meeting the city health and local sanitary matters will be considered, the Board of Health being invited to be present.

**BRITISH DIPLOMAS.**—Dr. E. M. Hewish (Toronto), has received his Diploma of the Royal College of Surgeons, England.

Drs. Dorland, Davy, Lawton and Stalker (Trin.) have taken the L. R. C. P., Edin., and Dr. W. F. Freeman (Trin.) has taken the triple qualification of the Colleges of Physicians and Surgeons of Edinburgh and Glasgow.

T. S. Covernton, M.D., L.R.C.P., Edin., son of Dr. C. W. Covernton of this city, has recently passed the examination for the Diploma of Sanitary Science in the University of Cambridge. This examination is the most severe of any of the kind in any part of the world.

**APPOINTMENTS.**—Dr. J. J. Gardner has been appointed Visiting Physician to the General Hospital *vice* Dr. Burland, resigned.

Drs. C. A. Sharpe and D. A. Cameron have been appointed on the assistant staff of the Montreal General Hospital *vice* Drs. Graham and Ferguson, resigned.

Dr. J. E. Jenner has been appointed on the assistant staff of the Toronto General Hospital.

Dr. A. T. Carson has been appointed lecturer on Botany in the Women's Medical College, Toronto.

**PERSONAL.**—The friends of the Rev. Dr. Johnston of Brownstown, Jamaica, the well-known missionary, will be pleased to learn that he has finished his medical course at Edinburgh, and has returned to the scene of his labors. He was greeted on his return most enthusiastically by his people and congregation. He took the degree of M.D. C.M. in Trinity Medical College, Toronto, and

subsequently obtained the double qualification of L.R.C.P. & S. Edin. We wish him continued success and prosperity in his good work.

**THE NEW SPECIFIC FOR RHEUMATISM.**—In the *N. Y. Med. Journal* for Nov. 8th, 1884, Dr. Seelye, of Amherst, Mass., gives an analysis of 118 cases of rheumatism treated with the new specific—the oil of gaultheria, or oil of wintergreen. His experience of its use has led him to place great reliance upon it in the treatment of all rheumatoid affections. It may be administered in capsules or combined with salicylate of sodium or in an emulsion of ten minims of the oil to half a drachm each of glycerine and water. Relief was usually obtained within from twelve to twenty-four hours.

**PICROTOXIN IN NIGHT-SWEATS.**—In the hope of obtaining a remedy that would control the exhausting night-sweats of phthisis, Dr. Cauldwell of St. Joseph's Hospital, New York, has made a series of experiments with several recognized remedies and has arrived at the conclusion that picrotoxin comes nearer the ideal than any other drug. It was prescribed in twenty cases, in seventeen of which the perspirations were either entirely checked or materially diminished. A single full dose  $\frac{1}{4}$  of a grain at bed-time was generally sufficient to control the sweating.

**HONOR TO WHOM HONOR IS DUE.**—We are pleased to announce that Dr. Joseph Workman of this city was elected an honorary member of the Phreniatric Society of Italy in September, 1883; also an honorary member of the British Medico-Psychological Association in July, 1884. We congratulate the worthy gentleman upon the appreciation of his labours by his confrères both at home and abroad.

**IMPOTENCE IN THE MALE.**—The following is highly recommended by Dr. Hammond, of New York:

R Strychniæ sulph.....gr. i.  
Acid phos. dil..... 3 i. M.

Sig.—Ten drops to be taken in a teaspoonful of fluid extract of coca before meals.

Dr. H. O. McLatchy, of Wolfville, N.S., has received a silver cup as a special prize for a specimen of apples at the fruit and vegetable show in the Crystal Palace, London, Eng.

**SCHOOL HYGIENE.**—A most excellent paper on "School Hygiene" was read at the Teachers' Association in the County of Essex, on the 23rd of October, by Dr. Coventry, of Windsor, Ont. It is published in the *Essex Record* for Nov. 7, 1884.

**MEDICAL COUNCIL ELECTIONS.**—We have been requested to state that Dr. Burritt, the present member for Newcastle and Trent, will not be a candidate for re-election. Having removed from the Territorial Division he is not eligible under the Act.

### In Memoriam.

**ISABELLA C. FULTON.**

*Born May 20th, 1844.*

*Died Oct. 28th, 1884.*

In kind and loving remembrance of a devoted wife, and a kind, loving and affectionate Christian mother, these lines are dedicated. Words can but feebly express the many good qualities of head and heart by which her life was so distinguished. The highest welfare and happiness of her husband and family were her constant solicitude and care, and no sacrifice was too great to accomplish her desires in these respects. Her memory will ever live in their affections, and her prayers will be taken up and repeated by those who were taught them so faithfully as soon as they were able to lisp. Her husband has lost a true and devoted wife, and her children have sustained the greatest of all losses—the influence, care, and example of a Christian mother. Her goodness of heart and faithful motherly example, won for her the deepest love and admiration of all who knew her intimately. Many a poor family will sadly miss her kind ministrations during this inclement season. Though not customary to use these columns for obituary notices except for medical men who have distinguished themselves in some way, it seems only a fitting memorial to one who contributed so much to the success of this journal, by the assistance she gave her husband in his labor, to consecrate a small space to her memory.

### Books and Pamphlets.

**THE POPULAR SCIENCE MONTHLY FOR NOVEMBER, 1884.** New York: D. Appleton & Company. Fifty cents a number, \$5 a year.

"The Relations between the Mind and the Nervous System, by Dr. W. A. Hammond, occupies the leading place in the November "Popular Science Monthly." He defines mind as a force developed by gray nerve-tissue, and maintains that this force is generated wherever in the living organism gray nerve-tissue is found, citing many striking cases in support of this view. He denies that either the absolute or the proportionate weight of the brain indicates a definite rank in intelligence. This number contains also Herbert Spencer's replies to recent statements made by Frederick Harrison as to the "Origin of the Synthetic Philosophy." Two thoughtful addresses delivered at the recent meeting of the American Association are given in full—"Pending Problems of Astronomy," by Professor C. A. Young, and "What is Electricity?" by Professor John Trowbridge. "The Future of the Negro in the South" is treated in a witty but convincing manner by J. B. Craighead, who evidently knows the Southern negro well. Among other interesting articles may be mentioned "Chemistry of Cookery," "The Oil-Supply of the World," "Sketch of Professor James Hall." The number is a promising opening for Volume XXVI.

**THE PRINCIPLES AND PRACTICE OF MEDICINE** BY N. S. DAVIS, M.D., Chicago, Ill. Chicago: Jansen, McClurg & Co. Toronto: Williamson & Co.

This work is not a compilation, but an embodiment of the observations, thoughts, and experiences of the author during nearly fifty years of active medical practice. The matter is presented in the form of lectures delivered by him during his many years of teaching. The features which especially commend the work to the practitioner and student, are the fulness with which the clinical history of the various diseases is given, and the explicit and detailed description of the methods of treatment which have been found most effective. The author's adoption of the metric system of weights and measures is worthy of notice and commendation. Although this system has been advocated by leading scientific and medical societies, it has come into use only to a limited extent. To assist in

effecting this change, Dr. Davis has used the metric system throughout the work, giving however, in brackets, the equivalents in apothecaries' measure. The author is well known throughout the United States and Canada as one of the ablest and most original thinkers in the profession, who has won a deservedly high reputation as a lecturer upon practical medicine; and the profession is to be congratulated upon having in a permanent form the rich results of his busy professional life.

**TEXT-BOOK OF PRACTICAL MEDICINE, FOR THE USE OF STUDENTS AND PRACTITIONERS OF MEDICINE** BY ALFRED L. LOOMIS, M.D. LL.D. with two hundred and eleven illustrations. New York: W. Wood & Co. Toronto: Hart & Co.

There is probably no clinical teacher of the present day better qualified to write a work on the practice of medicine. Many of his pupils will be glad to have a copy of his work for reference, and the general profession cannot fail to appreciate a work of such utility as the volume before us. The work is essentially an elaboration of the lectures given during the past eighteen years in the medical department of the University of New York. The author has done his work well, and has produced a book of which he may justly be proud. We regard it as second to none on the practice of medicine.

**MALARIA AND MALARIAL DISEASES.** By George M. Steinberg, M.D., F.R.M.S. William Wood & Co., New York.

This is a very exhaustive, pleasantly written and well arranged work, in ten chapters: i. Mode of infection or intoxication. ii. Conditions governing the evolution and dissemination of malaria. iii. General effects of malaria. iv. Speculations and researches relating to its nature. v. Antidotes to malarial poisoning. vi. Prophylaxis. vii. Geographical distribution. Part Second. viii. Malarial intermittent fever. ix. Continued malarial fever. x. Hæmorrhagic malarial fever. In these chapters the literature of the subject generally as well as the recorded experience of recent foreign writers is freely given, the whole forming a work of great practical value to general practitioners.

**DISEASES OF WOMEN AND UTERINE THERAPEUTICS** by H. MacNaughton Jones, M.D. New York: D. Appleton & Co.

**MEDICAL RHYMES,** BY HUGO ERICHSEN, M.D., with introduction by Prof. Willis P. King, M.D., Sedalia, Mo. St. Louis: Chambers & Co.

This work contains a collection of rhymes ancient and modern; grave and mirthful; rhymes anatomical, therapeutical and surgical, in short all sorts of rhymes to interest, amuse and edify all sorts of followers of Æsculapius, so says the author in his preface, and a casual examination of its contents would seem to bear out the statement. Some of the verses are very witty and humorous; some of a very high order of merit, and some very indifferent. On the whole the work is worthy of perusal, and will interest and amuse the busy doctor in his leisure hours.

**INDEX-CATALOGUE OF LIBRARY OF SURGEON-GENERAL'S OFFICE, UNITED STATES ARMY, Vol. v.** Flaccus-Hearth: Washington Government Printing Office.

This extensive volume is but one of a series of which the reader may form some estimate by observing that it embraces only those subjects in alphabetical order between the words *Flaccus* and *Hearth*. The labor in preparing this index must be something enormous, but when completed it will be the most extensive work of the kind in the world.

**LOCK-JAW OF INFANTS** by J. F. Hartigan, M.D. New York: Bermingham Company.

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### **Births, Marriages and Deaths.**

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On the 29th of October, Louis E. Day, M.D., to Jennie McAlpine, second daughter of John Harstone, Esq., merchant, Harwood, Ont.

On the 28th of October, Chas. W. Alden, M.D., of Hampton, N.B., to Margaret Hamilton, youngest daughter of Wm. Thompson, Esq., and neice of the late Hon. M. H. Foley.

In Toronto, on the 18th ult., George Willcock, M.D., L.R.C.P., Edin., aged 33 years.

In Halifax, on the 14th ult., Edward Jennings, M.D., in the 68th year of his age.

At Santa Barbara, California, on the 2nd ult., George W. Nelson, M.D., C.M., aged 26 years.

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*\*\*\* The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

# THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

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## Original Communications.

### ADDRESS ON MEDICINE AT THE ANNUAL MEETING OF THE MEDICO-CHIRURGICAL SOCIETY, OTTAWA.

BY J. A. GRANT, M.D., F.R.C.P., LOND.

Consulting Physician to the County of Carleton General Hospital;  
also to the General Hospital, Ottawa.

GENTLEMEN,—Thirty years have just passed since I had the pleasure and good fortune to become a member of the profession in this city. Our number was then small; we had neither telegraphs, telephones, nor electric lights, all of which have since been added, and in the immediate domain of the profession, vast strides have been made in every department, indicating alike the march of scientific advance in the field of labor in which we are called to duty. Let me thank you for the honor you have now conferred, in electing me President, and my son, Secretary-Treasurer of the Medico-Chirurgical Society for the ensuing year. I have on various occasions experienced your thoughtful consideration, and to be again honored, after so many years spent with you, is an evidence of your continued confidence, at a time when the termination of my professional career cannot be very far off, under ordinary circumstances. The life so far has been an exceedingly happy one, and my earnest desire has been to promote a mutual regard and self respect amongst our brethren, and thus unite our efforts in the discharge of the varied responsibilities entrusted to our care. The success of the medical profession depends greatly on close and continued observation, in order to eliminate the practical issues of bed-side experience, which after all is the light and lamp which cheers us on in our work. The efforts of a single individual can accomplish but little, compared with the combined exertions of various laborers in the same line of research. Each medical society should be a centre of intellectual co-operation, comparing, strengthen-

ing and fortifying, each new idea each ray of light, which may be thrown on any obscure point, until it intensifies and grows, so as to be worthy of the recognition of science. No man is perfect, and each day proves the vast importance of ascertaining carefully our facts, their mutual relations, and the deductions to be drawn therefrom. During this coming year let me invite your hearty co-operation and assistance. Our country is comparatively new, and our scientific societies and institutions, are gradually budding into practical usefulness. Canada and the Canadian medical profession are now better known in transatlantic centres of learning than at any previous period in our history, and all we desire is an honorable record. Each medical society is a parent cell of the intellectual medical structure, as a whole, of our Dominion, the reflex influence of which, for good, will greatly depend on united intellectual co-operation. Thus we will attain the esteem and good will of those at home and abroad and strengthen the ties which unite us together as a working body, working to make "our lives sublime," by the relief of suffering humanity. The march of progress in medical science we have evidence of in every department of the profession, and on this present occasion I shall invite your attention to a few lines of thought, now being thoroughly traversed, particularly in medicine, physiology, pathology, and therapeutics. The relationship of disease to minute forms of life is attracting the most careful enquiry in the field of microscopic research. Until recently, large bodies, rather than small, have engaged the chief share of attention. To-day however, we note that the small things of creation, such as fungi, blights, mildews, moulds and bacteria, so intimately associated with life and death, have aroused more than an ordinary degree of interest. By the aid of the microscope we can demonstrate those minute forms, rod-shaped, spiral, globular, filamentous, and termed bacteria, classed as vegetable parasites and capable of promoting general systemic disturbance. Earth, air and water contain these minute forms, and their mission is so directed as to manipulate the elements of disintegration and decay, and institute a purifying process. Bacteria may prove harmless or otherwise, in accordance with their peculiarity of action. In the performance of the various functions of life, thousands of these bodies enter the system, largely

through the lungs, and gradually make their way into the fluids of the lymphatics and blood-vessels. Should they find a basis of operation congenial, they will grow and multiply rapidly, and develop bacterial disease. The albuminoids and carbohydrates afford grand centres for their operation. They are active factors in putrid decomposition; transform sugar into lactic acid; lactic acid into butyric acid; alcohol into acetic acid, and sugar into a slimy gum. When these products of their activity find entrance into the human system, specific bacterial disease is produced. Then it becomes a question which shall prevail, the tissue cells of the system, which by their inherent power may overcome bacterial influence, or the bacteria overpower the system and induce death. They have a congenial soil when in active operation. The bacillus of splenic fever and consumption, and the bacillus anthracis, have their own characteristics, and may by cultivation part with their dangerous power, as far as promotion of disease is concerned.

Pasteur has demonstrated beyond doubt, that by introducing a minute quantity of diseased structure charged with its specific bacteria, into the tissue of healthy animals, that the identical disease is reproduced. What is still more interesting is the fact, that virulent and poisonous bacilli, can by cultivation, be so changed, as to part with their poisonous power. Here comes in the vaccinating principle of the bacillus; its prophylactic action against invasion of the original disease. We constantly observe in practice, how an attack of scarlet fever, measles, etc., almost precludes the possibility of a second such occurrence. The precise power is difficult to define, and parasitic action may be the chief factor in the remarkable protection. We know well what vaccination has accomplished, and the same principle may yet be so arranged as to place under control many zymotic diseases which still scourge the human family. The question of the precise relationship of organisms to the processes of putrefaction and fermentation, is beset by diversified views; followers of Pasteur's germ theory, holding that bacteria are invariably the initiators of these chemical changes, while others contend that putrefaction and fermentation may take place, independent of these low forms of life. The question of cause and effect, as associated with bacteria, is an interesting problem, and now engaging the

attention of master minds, particularly with reference to the cholera microbe, and the bacillus of tubercle, and let us hope that the result will be both practical and useful, as far as the arrest of disease is concerned. While on the subject of the cholera microbe let me remark, that judging from present indications, cholera is most assuredly gradually moving onward in the course previously taken in 1832 and 1854. In Paris the daily death-rate is quite alarming. The present is the time for activity in carrying out sanitary precautions, so as to be prepared for the advent of spring. Through steam, commercial communication has rapidly increased, and centres of trade thus placed in close relationship, hence the necessity for prompt action. Sanitary rules and regulations are of little service, unless carried into operation. Prevention is a powerful factor, and let our efforts be so directed as to guard the best interest of our people. In this brief introductory I find the subjects so closely interwoven, that with difficulty can the line of thought be isolated. Physiology and pathology have so much in common that they never can be separated, because as sciences they have the same organs and the same functions, under normal or abnormal conditions. It is important that the normal or abnormal condition of an organ should be studied, on the principles of a mutual intercourse. Functional activity and organic change are co-operating powers closely interwoven, which must be noted carefully, in the broadest sense, as progressive evolution in tissue occupies the place of the once healthy organ. Thus comes in the important application of physiological discovery, as an additional prospect for the relief of diseased structure. Lymphatics and leucocytes are points at present possessing more than an ordinary degree of interest, as to the precise part they play in the structure and functions of the system. Blood and lymph are the chief juices of the body, and on that account the purity or impurity, the normality or abnormality of either, directs, controls and determines the powers of the system in structural development, as well as decay. According to Zeigler, the lymph is merely the liquid transuded from the blood vessels, together with certain products of tissue metabolism, and certain matters taken up by the lacteals from the outside. The sources of lymph being so diversified, it is not surprising that occasional morbid changes in its composition

should take place. Until recently the mediastinal and mesenteric glands were the chief source of attention in this important department of absorbing power. In this field of labor Dr. Philipson and Professor Redfern have certainly rendered most valuable service. The lacteals and lymphatics are constantly occupied in supplying the blood with fresh material, from two great sources of life, air and food, and thus become supplementary to the general vascular system. It is a settled point that in the extremities, the deep and superficial lymphatics communicate only in the glands, and that the pleura, peritoneum and pericardium, are not closed cavities, but immense lymph sacs, communicating with lymphatic capillaries, by means of stomata. Thus we observe the existence of an additional lever as to the absorption of abnormal products, and a system of escape, into the general lymphatic channels. Hoggan (*Journal of Anatomy and Physiology*) has defined a newly observed disease of the lymphatics, viz., multiple lymphatic nævi of the skin, thought to be quite as common as venous nævi, which it frequently complicates, and is also the initial or predisposing stage of other diseases, such as lymphatic varix of the larger vessels, and also of elephantiasis. Dilatation of lymphatics is most common in warm and moist climates, and to Manson we owe the interesting discovery, that a prolific cause of dilatation in these vessels, is owing to plugging by the aborted ova of the "*Filaria sanguinis hominis*." The causes and processes of disease, now occupy more attention than anatomical results; and the experimental production of disease is slowly working its way, and will doubtless lead to very important data. How strangely blood, the great vital fluid is disposed, and its abounding leucocytes. What their function, or what part they play in the economy, is yet unsolved. From the fact of being in the blood so abundantly, we would suppose an intimate relationship, with life-giving processes of action. On the other hand however, we note numerous masses of leucocyte-shaped cells, in the vessels surrounding, rapidly developing sarcomatous tumors. Are there leucocytes of life, and leucocytes of death? Long since the blood was considered as the source of cancer, and certainly the close affinity of leucocytic action becomes an exceedingly interesting physiological problem. Another constituent of blood intimately associated with structural development, and at

times ejected as abnormal material, is albumen. Clinically its importance has undergone considerable modification, as far as constantly being a factor of organic disease is concerned. In truth it is known that we may have kidney disease, minus albumen, and *vice versa*. Johnson, of King's College, London, affirms that "the smallest trace of albumen in the urine is always pathological." It is "the frequently recurring and persistent albuminuria which is found to be sooner or later associated with serious structural degeneration of the kidney." By far the most numerous cases of albuminuria, are those occurring in persons supposed to be healthy, but who at some previous period, have had an attack of acute renal trouble. Quasi health with latent disease, frequently follows such attacks, and cannot be too cautiously guarded. It is interesting to have in view the fact that while urine voided before breakfast, and after a night's rest, is free from albumen, yet, after food and exercise, it may become abundant. Renal or non-renal albuminuria, is the question. It is known that frequently, both before and after menstruation, for a few days at least, the urine may contain a small quantity of albumen. Various trivial causes are cited as producing albumen in the urine, and amongst others, indiscretions of youth. The absence of constitutional evidences of renal disease, with urine normal in every other particular, excepting albumen, would point to a local origin, non-renal in character. Albumen under any circumstance cannot be too critically examined. In Canada my observation leads me to the belief, that the most prolific source of kidney-trouble, is alcohol; not alcohol in large quantities, but the quiet, and regular use, in the daily round of life. Many escape this disease, thanks to the power of their kidneys, but on the other hand, not a few come to grief. Night micturition is an early indication, and alcohol has actually been found in the urine, having escaped thus, from the over charged system. Albumen is, then, only sometimes present. Too much stress cannot be placed on the power which alcohol exercises on the system, even in moderate form, towards the development of albuminuria. The study of diseased manifestations, naturally leads to the means at our disposal, the therapeutic lever, and how to be applied. The only true method by which practical results can be achieved, is by experiments on the lower animals;



statistical observation of the results of treatment, and lastly individual observation. Could our local society not be constituted a collective investigation committee? At present each member works in a practice circle of his own. Could the various circles be united, as to practical results, much valuable information would be brought together. What can possibly be more diverse than the treatment of disease? In many diseases, the very multiplicity of remedies recommended, by the most advanced authors, for the relief of the same, tend to throw doubt on therapeutic action. Cholera, diphtheria and typhoid fever. How varied the recommendations for this tripod of disease! The uncertainty of medicine is well known, and still how frequently we note its practical utility. The non-reliability of the materia medica is daily decreasing, and how? by the careful and patient study of philosophical and physiological facts. Thus the reactions in human chemistry are worked out on plain and simple principles, providing nature's laboratory is not overburdened by the endless variety of pseudo-medical nostrums, placed before the public in popular form. It is somewhat remarkable how few of the many therapeutic agents upon which we pin the greatest reliance, have been the result of direct experiment, or scientific enquiry. We recognise the power of quinine in intermittent fevers, and debilitated states of the system generally, and yet how defective is our knowledge as to the precise action of this material on the system. Again, we all note the power and influence of bromide and iodide of potassium, and yet their employment has not been the result of scientific induction, as the outcome of either physiological or pathological enquiry. In this line of thought much doubtless has been accomplished, but there is still much to learn. In Canada fortunately there is no legislative enactment against "vivi-section," one of the greatest possible blessings of humanity, as a means of carrying out scientific research. In the development of Canadian history and interests, we hope to see more time and means devoted to original investigation. Discoveries, through scientific enquiry, in the direction of the human system, would be exceedingly gratifying records, in the march of progress in our new country. We have an intellectual activity of no low order, and with our naive growth, schooled at home and abroad, in the most progressive centres of Great Britain and Europe,

we naturally look for, and anticipate competitive scientific enquiry, into the complex operations of a system which has thus far taxed the most acute observation in solving the problems of life. "Not what I have, but what I can do, is my kingdoms," says Thomas Carlyle. Fortune may not be our lot; but an honest living we shall have, and with the trust placed in our hands, let us so discharge our duties as to gain the esteem and respect of our fellow-men.

### A RECORD OF CASES TREATED IN THE ROYAL INFIRMARY, FROM NOV. 1883 TO MAY, 1884.\*

BY ANGUS MACDONALD, M.D., F.R.C.S.E.  
Physician to the Infirmary.

#### FIBROID TUMORS OF THE UTERUS.

A. N. æt. 36, unmarried, was admitted Nov. 5, 1883, complaining of a swelling in her abdomen. Patient has always enjoyed good health till three years ago, when she felt a severe pain in her back which lasted only three days. Twelve months before admission the same kind of pain returned and since then it has been constant. The pain induced her to go to the doctor who told her there was something wrong with her inside, and advised her to go to the hospital.

*Condition on admission*—Abdomen distended to about the size of a seven or eight months' pregnancy, but somewhat irregularly, the long end of the oval being oblique upwards from left to right, from the middle of Poupart's ligament on the left side to the top of the last rib on the right side. Tumour is perfectly moveable. Percussion is uniformly dull anteriorly, resonant on both sides, especially on the left. On the right the tumour feels solid, on the left obscure fluctuation is present. In front a soft flat cyst containing fluid can be distinctly felt and it is freely moveable over surface of solid mass behind. On auscultation an impulse is communicated to the ear from all points of the surface of the tumour. On the lower aspect anteriorly a distinct bruit is audible synchronous with heart's first sound. *Per vaginam*—Hymen persistent, pelvis empty, and the vaginal portion of the cervix is represented by a button-like nodule of firm tissue. From this nodule the thinned elongated cervix can be felt extending up-

\* Read before the Obstetrical Society, Edinburgh, June, 1884.

wards to the tumour, a distance measured by the sound of between two and three inches. Nov. 23, 1883, Dr. Macdonald opened the abdomen; there were no adhesions whatever. Before the tumour could be removed the incision had to be extended gradually from the symphysis pubis to  $1\frac{1}{2}$ -2 inches above the umbilicus. Both ovaries were high up and placed the left anteriorly and the right posteriorly on the tumour. There was a marked twist from left to right forwards; the amount of rotation was quite a quarter of a circle. The neck was elongated and formed a fairly good pedicle. This was embraced by Tait's clamp and secured. The tumour was now cut off about an inch above the clamp. There was very free hemorrhage from the tumour during the operation. The end of the stump did not bleed at all. A further portion of the stump was removed by scissors. The abdominal wound was now secured by thirteen deep and numerous superficial sutures. A quantity of salicylic wool was placed over the wound, a bandage applied and the patient put to bed, and attended to in the usual manner. The whole operation took sixty minutes, and the tumour weighed ten pounds. The patient made an uninterrupted recovery; the highest temperature registered during the convalescence was 99.4 which occurred at 11 a.m. on Nov. 24; pulse averaged 65. Over the stump a little powdered iodoform was sprinkled. No opium was administered. The bowels were moved with castor oil for the first time on 1st December. The deep stitches were removed on the 9th day when complete union by first intention was found throughout. The superficial stitches were taken out on the eleventh day. The clamp separated on Dec. 16th, 1883. January 24, 1884, wound quite healed. The end of the vagina could not be reached; patient discharged.

*Remarks*—The operation in this case was necessitated by the pain occasioned by the rapid growth of the tumour. There was no trouble from bleeding. The medical attendant who sent the patient reported that the tumour appeared to him to double its size in the course of two months. The bulk of the tumour was made up of degeneration of the anterior wall of the uterus, the body of the organ being round its posterior surface. The marked twist in the tumour is of importance in its bearing upon the treatment of removal of the ovaries for the purpose of arresting the growth of

fibroid tumours. Whilst the left ovary could have been easily removed it would have been completely impossible to reach the right. Before proceeding to operate we had made out clearly that the tumour was clear of the pelvis and had an elongated cervix, two points of the greatest importance in facilitating the operation. The loss of time which occurred in sewing up the abdominal wound arose from the efforts made to secure as completely as possible the lower angle of the wound below the pedicle. In attempting to do this the needle broke and led to considerable delay.

CASE II.—M. B. æt. 54, admitted Feb. 21, 1884, complaining of a swelling in her abdomen and of pain in the swelling. Patient first noticed a lump in her abdomen eight years ago, since that time the lump has gradually increased in size, and during the three weeks previous to her admission it has rapidly grown much larger and feels harder and more pain is present. Patient also states that for two or three weeks before admission she has passed less water than previously, and there has been a disagreeable pain in her back.

*Condition on admission*—Abdomen is occupied by a large tumour distended to the size of full-term pregnancy. Tumour is hard, moveable, rounded, smooth and oval in shape. Friction is heard anteriorly, soft bruit is audible, synchronous with first sound immediately above pubis in mesial line. Measurement round most prominent part ( $3\frac{1}{2}$  inches below umbilicus) =  $47\frac{1}{2}$  inches. From right ant. sup. spine of ilium to umbilicus  $8\frac{3}{4}$  inches, from left ditto 9 inches. From umbilicus to pubis 9 inches, from umbilicus to ensiform cartilage 9 inches. All over surface of tumour percussion is dull, flanks clear, also clear between ensiform cartilage and upper border of tumour. Vagina rather narrow and elongated, cervix can be felt with extreme difficulty at its upper part, at a level with the upper edge of the symphysis; no part of the tumour can be felt per vaginam, but only one finger can be passed. Sound enters upwards and towards right side, three inches. Urine passed in 24 hours was 24 oz., containing albumen, blood, pus, renal epithelium and blood casts. Patient was put on milk diet, the quantity of urine increased to 50 oz. during the 24 hours, and the week before she was operated on only a trace of blood and albumen could be detected. On the 4th of April Dr. Macdonald performed laparotomy.

The peritoneum was speedily reached ; on passing the hand round the tumour it was found to be free from adhesions. The uterine tumour had so developed as to bring the left ovary forwards and upwards as high as the umbilicus, thereby producing great tension on the left broad ligament. The incision was gradually increased by one-quarter inch at a time, upwards, until the tumour could be pushed through. It was then found that the tumour had a very short pedicle ; round this was passed a Tait's clamp, which was securely tightened. The tumour was now cut off, about an inch above the clamp ; the hemorrhage was found to be completely arrested by the clamp. The edges of the incision were now brought together by deep and superficial stitches. The superfluous tissue of the pedicle was cut off by scissors and the stump dressed by being freely dusted over by a mixture of equal parts of bismuth and iodoform. The rest of the wound was covered by a layer of protective lint. The woman was then put to bed and had a brandy enema administered. The patient made an excellent recovery. The highest temperature reached was 99° F. She passed wind on the third day, and the bowels were moved on the eighth day after castor oil had been given. The deep stitches were removed on the seventh day, the clamp on the 30th of April. The tumour weighed eight pounds.

*Remarks.*—In this case also the operation was required on account of the bulk and rapid growth of the tumour. It was found to be developed in the posterior uterine wall, the body of the uterus being stretched over its anterior surface. In this case also, removal of the right ovary which lay behind the tumour low down would have been impossible. There were several considerable cavities developed in this tumour, indicating its tendency to fibro-cystic changes. It is also to be noted that the pressure of the tumour appeared to have caused the renal disturbance noted on admission. At any rate when the patient came in there was scanty urine containing blood, casts and albumen. Rest and appropriate treatment speedily rendered the urine both plentiful and healthy. The pedicle in this case was exceedingly short, and as the patient's abdominal walls were very thickly covered with adipose tissue, the clamp sunk deeply into it, and on the left and right side caused a certain amount of ulceration, but on the removal of the clamp

these symptoms rapidly improved. The difficulties connected with the external method makes us sigh for a valuable internal method in this operation ; but the risks of bleeding and of infection are so great that I have not seen it advisable to attempt the internal method ably practised by Schröder.

**CASE III.**—M. A. B. æt. 51, admitted January 9, 1884, complaining of enlargement of the abdomen. Patient has menstruated during the last seven years, but her abdomen has been gradually increasing in size. Appears in good health apart from the inconvenience of the tumour.

*Condition on admission.*—The abdomen is occupied by a more or less rounded, moveable, resistant, hard tumor. Abdomen widest girth measures 39½ inches. Percussion absolutely dull up to 1½ inches below umbilicus, in both flanks note clear. Auscultation gives negative results.

*Examination per Vaginem.*—The posterior part of the pelvis at its upper end, and a great part of the inlet is occupied by a large tumour, soft anteriorly, hard posteriorly. Arching in a semilunar manner in front of the anterior part of the tumour is a thin, valve-like tissue, which seems to be the thinned anterior lip of the cervix. Using this as a guide, the sound passes up and towards the right 3¼ inches. This case admitted of no surgical treatment, more especially as there was no hemorrhage to complain of, and she was dismissed on 24th Jan., 1884, in *statu quo*.

**CASE IV.**—J. D., æt 43, admitted Feb. 15, 1884, complaining of a tumour in her abdomen. Patient first noticed the tumour four years ago; it has grown slowly and has not been uneasy lately. Menstruation was profuse, but is not so much now as it was nine months ago.

*Condition on admission.*—The lower part of the abdomen is projected by a tumour of uneven outline, which extends as high as the umbilicus. It is firm, not tender, and freely moveable. On the lower parts of the tumour a bruit synchronous with the heart sound is audible. The girth round the most projecting part of the tumour is 34 inches. Vaginal examination reveals a rounded tumour occupying the posterior part of the inlet continuous with the tumour in the abdomen and moving with it. In front of the os there is also projecting into the anterior part of the pelvis a rounded mass similarly related to the tumour. Sound en-

ters upwards and forwards barely 3 inches without pain. The patient is rather anæmic. She was ordered ergotine suppositories and a chalybeate tonic, and after a rest in the hospital was dismissed on March 23, 1884, as an unsuitable case for operative interference.

CASE V.—M., æt. 48, was admitted on April 9, 1884, complaining of a continual sanguineous discharge and pain in her back. Her illness dates from a miscarriage she had 7 years ago. Patient has had six children and two miscarriages.

*Condition on admission.*—Patient is very anæmic looking; a systolic murmur is present in all the cardiac areas. Abdomen occupied inferiorly by a rounded, moveable, almost fluctuating tumour, which extends 5 inches above the upper edge of symphysis pubis. The tumour is more developed toward the left than toward the right, although on the whole it is centrally placed. A bruit is heard immediately above the symphysis. Per vaginam the cervix is reached with some difficulty. It is considerably undone, the lower os being traversable to the examining finger which passes in  $1\frac{1}{2}$  inches, cervix passes right into tumour which is moveable. No part of the tumour is contained in the pelvis. April 23, patient left hospital owing to domestic affliction.

*Observations.*—The foregoing cases differed considerably in symptoms and conditions. In case 3 there was no hemorrhage, but the patient applied for relief on account of the bulk of the tumour. There was, however, no evidence to show that the mass was growing fast, and the absence of bruit indicated no great vascularity in the tumour. The difficulty and the risks of removal, when the cervix was undone, and the tumour found to grow so deeply between the layers of the broad ligament, appeared to me so great that I declined to interfere by operation, and accordingly the patient left. I have not heard from her since. Indeed such cases present insuperable difficulties to removal, partly because there is nothing from which to make a pedicle, and partly on account of the enormous adhesions which are found round the mass when the broad ligament is opened up and the downward and outward growth of the tumour occurs. The same remarks apply to cases 4 and 5, only that in regard to them the bleeding was an urgent symptom. But in case four the hemorrhage though still pre-

sent, appeared for several months past to be steadily diminishing; accordingly, I contented myself with recommending ergotine and iron, in the hope that the patient's strength might be kept up until the menopause was fully established, when there is every reason to expect the tumour would shrink and give little further trouble. But case five presented so much distressing bleeding that operation was seriously contemplated. The case did not present a good one for hysterectomy as though there was no pelvic adhesion and no considerable opening out of the broad ligament, the length of the cervix was so encroached upon as to render it all but impossible to get such a pedicle as a clamp could secure. Accordingly I had made up my mind to try the effect of the removal of the ovaries in the hope of inducing a premature arrest of menstruation, and thus removing the most pressing symptom, viz: dangerous flooding. The sudden illness of a daughter of the patient led her to leave the hospital unexpectedly. She was to return if the bleeding continued to be serious, meanwhile she was to employ ergotine and quinine pills. She has not as yet applied for readmission.

#### ON RAILWAY SPINE.\*

BY J. CAMPBELL, M.D. L.R.C.P., ED., SEAFORTH, ONT.

The ever-interesting and ever-important subject of what now generally goes by the name of "Railway Spine" has, during the last year, been attracting renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and Spinal Cord." Mr. Page has been for a number of years a surgeon to one of the greatest railway corporations in England, and, therefore, has had a very extended experience of all possible railway injuries, and particularly of cases of so called "railway spine." He contends that cases of what are commonly called concussion of the spine do not exist, except in the imagination of the surgeon making the diagnosis. By "concussion," he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt. It is well known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms

\*Read before the Canada Medical Association, Aug., 1884

spinal symptoms are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He at least conclusively shows that the vast majority of cases of concussion of the spine are nothing more nor less than cases where the lumbar muscles or the ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents never recover, while Page, on the other hand, maintains that these so-called cases of "spinal concussion" always do recover. While representing the reaction, Mr. Page's recent work certainly favors an undue belief in the certainty of recovery in cases of this sort. Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents, may lead to a long train of nervous symptoms, and when death has resulted, a post-mortem examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution, will need a great deal of experiment and careful and extensive post-mortem investigation. The great trouble in coming to an opinion as to the nature and causes of a train of nervous symptoms following a railway injury is not whether we have to do with a functional or organic change but whether we have to do with an actual or feigned train of symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble; but when he has to do with an intelligent and unscrupulous man, who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is quite impossible to come to a certain diagnosis. In the words of a recent writer, "the needed clinical work, it seems to us, in the study of "railway spine," is the determination of clearly defined types of the disease and the investigation of the varieties from this type and the certain relation of objective symptoms to the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of *Brain*, there is a very instructive case reported by Dr. Edmonds of a soldier who was struck in the

back with a bullet. The bullet entered the back two or three inches from the spine, and the surgeon who first attended him considered that the spine was severely injured because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bedsore over the sacrum before death, which occurred five months after the injury. At the autopsy, there was no fracture or indication of fracture or dislocation of the vertebrae to be found. The corda vertebralis was intact. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Müller's fluid, it was seen that there was universal myelitis and softening for about two inches opposite the wound; this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts and above into sclerosis of the posterior median columns. There was no indication of hemorrhage, either external to or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate paraplegia following the injury could not have been due to any other cause. The case is then one of very great importance, as it proves most conclusively that we can have, from a severe shock, sufficient changes brought about in the spinal cord to bring about death, and that these changes are, in the first place, nothing more nor less than "concussion of the spine."

Very recently the opinion appears to be gaining ground that we may have a *tabes dorsalis* arise from peripheral causes; that in fact, an ulcer in the foot may be *fontis et origo mali* of this formidable disease. The origin of the disease in such a case is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

#### EXTENSIVE RUPTURE OF THE URETHRA WITH SATISFACTORY RESULTS.

BY CLARKSON FREEMAN, M.D., MEILTON, ONT.

On the 21st of February, 1884, W. R., æt. 29, farmer, fell from the top of an ice house, a distance of over ten feet, astride the edge of an inch board sleigh box. There was no abrasion of the skin, but

blood came freely from the urethral canal at the time of the accident, and oozed continuously for ten days. He was unable to urinate, and after several ineffectual attempts to introduce a No. 10 catheter I succeeded with a No. 5 gum elastic one, which remained nine days, and was replaced by numbers 6, 7, 8, 9, 10, 11 and 12 consecutively, at intervals of, on an average, seven days, according to the degree of irritation, or the presence or absence of vesical tenesmus. The rupture was nearly three inches in extent on the under surface of the urethra, between the scrotum and the prostate gland. The patient was kept constantly in the recumbent position, with his legs flexed, in consequence of his testicles being painfully swollen and extensive tumefaction of the perineum with ecchymosis from the anus to the prepuce of the penis, which remained for weeks. He had high fever with chills for some days, resulting from the formation of an extensive perineal abscess, which I opened on the 8th of March, to the great relief of the patient. The matter was copious and characterized by a most abominable stench. Under the use of disinfectants the abscess soon improved, but continued to discharge until the 15th of June. On the 14th of March by neglecting to remove the plug from the catheter in defecating, the urine was forced around the catheter and made its exit freely from the perineal opening. This frequently occurred afterwards by the slightest effort of straining. The abscess was syringed freely with milk and a small quantity of liquor morph., after each occurrence, as well as the bladder, whenever there were symptoms of mucus or approaching vesical tenesmus, which always mitigated the patient's intense suffering. The shortest time the catheter remained in the bladder was four days, and the longest 13 days. The fistulous opening thus formed from the abscess remained about three months, through which urine frequently escaped freely towards the last without producing any pain or uneasiness. The catheter was retained in the bladder continuously for 68 days after the receipt of the injury, until prostatic pain occurred and blood began to ooze from the bladder. On consultation with my brother, Dr. Wm. Freeman, the catheter was removed. The volume of urine was greatly increased and came away without the slightest effort for five days, when it began to diminish gradually until the ninth day, when he was unable

to micturate. Number 8 catheter was passed with slight difficulty beyond the seat of stricture daily, and 9, 10, 11 and 12 were again used at intervals, but not allowed to enter the bladder. No. 11 was mostly used before micturition. This precaution was persevered with over a month, until a perfect cure has resulted in one of the gravest accidents which may occur to any person.

He had frequent attacks of orchitis, which were allayed by hot fomentations, and the subsequent use of the suspensory bandage. I would suggest the use of vulcanized rubber catheters in the treatment of analogous cases, as they do not become easily corroded by constant use.

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### Correspondence.

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To the Editor of the CANADA LANCET.

SIR,—As a tribute to his worth, and as a matter of sad intelligence to many of your readers, I have thought a brief history of the sojourn, sickness and death of Dr. Ed. M. Hoople, of Toronto, Ontario, Canada, in this city, might prove acceptable to the columns of your very able and excellent journal. About six months ago, after an extended prospecting tour through most of our western States and Territories, Dr. H. reached this young metropolis of the south, "a stranger in a strange land." A partnership was suggested to him by a friend, and he called upon me with that object in view. I told him that though frequently solicited, I had never thought it expedient to take in a partner, but would very cheerfully extend to him the privileges of my office, and assist him in establishing himself with our people by every means in my power. From that hour until the advent of his last illness, he was my daily companion, friend and valuable assistant.

Dr. Hoople was a young man of thorough medical education; an honored graduate of the Royal College of Physicians and Surgeons, Edinburgh, and one who, had he lived, was destined to add lustre to the bright galaxy of names which already adorn the roll of graduates of that renowned institution. He was a man of modest, retired and cultured deportment, self-possessed in the confidence of his ability to "measure lances" with the best trained medical men of his age, from the thorough medical training to which he had been subjected,—yet, withal, having too much self-

respect to obtrude his opinions or judgment uninvited. His mind was analytic and quickly synthetic; his memory unusually retentive; his heart was unselfish and sympathetic, and his hands ever ready to assist those in need of help. He placed but little value upon money, save as a means of contributing to the comfort and happiness of others. With such a character as this, it is needless to say that in his new-found southern home, which he seemed to love with a pride and admiration as if begotten of many years of residence here, he soon won a host of friends, whose daily evidences of esteem in life, whose untiring and tender care and watchfulness during his illness and when death had cast its sable mantle over his noble frame, whose moistened eyes, soft and noiseless steps and low whisperings of love and sadness round his bier, more sweetly and beautifully attested their devotion, than empty words can express. He was fast gaining the confidence of our best people as to his professional abilities and skill, and had he lived, would soon have reached a self-sustaining if not a lucrative practice. He was fond of surgery and while here performed several skilful and delicate operations. He was taken down on the 25th of October with typhoid fever, complicated with hæmorrhage of the bowels, and died on the 3rd of November. I am greatly gratified to say to his aged mother especially—whom he loved and revered with the purest filial devotion—and his friends generally, that I believe he found peace, consolation and salvation by trusting in the atoning blood of Jesus Christ.

He had every attention that tender and skilful nursing could give. His prayers for the kind friends he had made, and especially for those who had waited and watched so lovingly and constantly over his sick bed, brought tears to the eyes of some unaccustomed to weep on such occasions. We feel comforted in the reflection that his was one of those cases in the experience of every physician, when every remedy has failed, which teaches us the impotency of man and the omnipotence of God.

Yours, etc.,

G. G. ROY, M.D.,

*Prof. Materia Medica, Southern Med. Col.*

ATLANTA, Ga., Nov. 25th, 1884.

## Selected Articles.

### REMOTE PUERPERAL HÆMORRHAGE.

Prof. T. Gaillard Thomas, M.D., of New York, gives the following in the *N. Y. Med. Jour.*, Sept. 6th:—Since I last attended a meeting of the society I have met two cases which have suggested to my mind the considerations which form the basis of what I am about to say. I refer to a form of hæmorrhage which comes on three weeks or a month after labor, after the physician has ceased making his visits. Some years ago the late Dr. M'Clintock, of Dublin, wrote a paper on this subject, and called it "remote or delayed puerperal hæmorrhage," and Dr. Mundé has recently written an article bearing upon the same point, published in the "*American Journal of Obstetrics*." I have seen a good many of these cases, and the history of one which I will relate illustrates the experience that I have had with most of them.

In such a case the uterus may have contracted after labor, and everything have gone on properly until the ninth day, when the physician has ceased to make his daily visits, but from that time the woman begins to lose blood steadily. If she makes a little unusual effort, or if anything occurs in the family to cause considerable mental excitement, an exceedingly dangerous hæmorrhage may take place, which will require to be checked with the tampon. If sudden and profuse hæmorrhage does not occur, demanding the services of a physician immediately, a steady loss of blood in moderate amount may continue for a week or ten days, until the woman becomes very much exhausted.

The particular case of which I have had the history in mind in the foregoing remarks, was that of a lady to whom I was called in consultation by a German physician of considerable experience. Ten months before, the patient had called at my office, and had given a somewhat peculiar history. She had been married for several years, her husband was a vigorous, healthy man in every respect, and she a remarkably handsome and well-formed woman; and yet no intercourse had ever occurred. On examination, it was found she was suffering from a very aggravated form of vaginismus. Her husband had exhausted all his efforts, and her mental state had become such that she could not entertain the thought of sexual intercourse. An operation was performed, at the end of a month the patient left the hospital, and just nine months later she was delivered of a child. About the end of the seventh month of gestation the veins leading from each labium majus became greatly enlarged, and the parts presented the appearance of a mass of earth-worms of the size of one's fist. I had seen the condition in so marked a degree but once or twice before.



On the ninth day after delivery hæmorrhage occurred, and she sent for her physician, who used all the ordinary means, including ergot, tannic acid, dilute sulphuric acid, etc., for stopping it, but without avail. The tampon, however, was not resorted to. About three weeks after her delivery the patient was seized with very profuse and violent hæmorrhage, which reduced her very much. It came on after she had got out of bed. When her physician reached her the hæmorrhage had ceased. Each time it had begun with the passage of a large blood-clot. On this occasion I was consulted, and I visited the patient three days later—the next time that hæmorrhage occurred. I took with me a nurse and instruments for dilating the uterine canal and for removing the remains of membranes. Her physician, however, felt very positive that none of the membranes had been left in the uterus, and stated that he had examined the placenta very carefully, and that there was no interruption of its continuity whatever. But I felt equally positive that some of the placenta yet remained in the uterus.

When the patient had been placed on the table and the ether-cone applied over her mouth, she suddenly sprang up in a state of wild excitement, and could not be induced to continue the inhalation of the ether, it had affected her so badly when she was operated upon for vaginismus. All means of persuasion were futile, and her friends desired that she should be compelled to take the anæsthetic. But I objected to compulsion, because, under such circumstances, after delivery, I have seen most violent and uncontrollable mania developed. In one instance the mania continued three weeks, during which time the patient was very violent, and had to be watched constantly by a nurse. It is true, the mania seemed to be of an hysterical nature, but, nevertheless, it was very violent. I think we cannot be too careful as to doing that which is strongly opposed to the will of a puerperal woman. I would rather have run the risk of a violent hæmorrhage in this case than have forced the patient to take the ether. She was spoken to kindly and put back into bed, and I assured her husband that she would send for me again within twenty-four hours, to have the operation done.

I was sent for the next day. The patient was then etherized, the uterine canal dilated, the curette was passed, and three pieces of placenta were removed, each as large as the last phalanx of one's index-finger. Very little hæmorrhage was excited by the operation, and I felt that in removing the pieces of placenta I had removed the cause of the hæmorrhage.

The points I wish to make are these. The case was an interesting one: 1st, with regard to the vaginismus; 2nd, with reference to the condition of the veins of the vulva; 3rd, with reference to the danger of giving ether during a state of maniacal

excitement; 4th, with reference to what I believe to be the usual cause of delayed puerperal hæmorrhage and the proper means for its cure.

With regard to the statement, so often made, that the placenta has been examined carefully and found entire, it usually amounts to nothing. In the first place, we know that the physician commonly looks at the after-birth hastily and in a careless manner. Besides, I believe that little pieces may be broken off and left behind, which no man could recognize from an examination of the placenta, though he examined it with the utmost care. As in this case, so in all others of delayed puerperal hæmorrhage that I have met with, it has been due to retained placenta or membranes. Dr. McClinton mentioned a case in his practice which, I believe, proved fatal. I have met with some which very nearly proved fatal, and doubtless some of those present have encountered similar cases.

## TREATMENT OF ACUTE, PULMONARY GANGRENE.

Among the excellent voluntary papers presented at the last meeting of the Illinois State Medical Society, was a contribution to the surgical treatment of acute pulmonary gangrene, by Prof. Christian Fenger, M. D., of Chicago. The paper deserves and will elicit general attention, both from its intrinsic merit and as indicative of progress in American surgery.

As advised at the present time, four operations for acute pulmonary gangrene have been performed.

The first operation was performed in 1879, by Messrs. Lawson and Cayley, of England, in a case of five weeks' standing. Decided amelioration of symptoms, as regards cough, dyspnoea and fetor, was observed. The patient died of exhaustion four days after the operation. The autopsy disclosed facts which led the operators to believe that an earlier operation would have saved the patient's life. (Med. Society, London, 1880.) Mr. Solomon Charles Smith, of Halifax, performed the second operation in 1880. The patient was in the second week of croupous pneumonia, when gangrene occurred in the lower lobe of the left lung. The patient lived ten days, with marked improvement in cough, dyspnoea and fetor. No autopsy was made. Professor Buhl, of Christiana, performed the third operation in 1880. Acute gangrene in the anterior portion of the left lung was the indication for operation. After a long convalescence of six weeks the patient recovered.

The fourth operation was performed by Professor Christian Fenger, of Chicago, in the Cook County Hospital, in April, 1884. The patient, male, 34 years old, was in the second week of croupous pneumonia. Signs of consolidation and formation of a cavity in the right infra mammary region,

extending into the right axilla, were elicited by auscultation and percussion. Cough was distressing and dyspœna great; about one pint of extremely offensive sputa was daily expectorated. The patient lost all appetite and rapidly progressive emaciation supervened. A cavity was found, upon the introduction of the needle of a hypodermic syringe through the thoracic wall, in the right infra-mammary region. An incision was made parallel to the clavicle; the ribs excised to an extent sufficient to secure access to the part, and the needle re-introduced within the cavity, as a guide. The cavity was then cut down upon by the small platinum pole of a Paquelin's thermo-cautery, and an opening sufficient to admit the index finger secured. Digital exploration revealed no detached gangrenous masses. Accordingly, the cavity was gently washed out, a drainage tube inserted, and the usual antiseptic dressing applied. Hemorrhage during the operation was trifling, but washing out the cavity produced very troublesome coughing. The patient speedily reacted from the shock of the operation, which was relatively slight. Five hours after the operation, appreciable diminution in the fetor was noted; at the end of the first week, expectoration was minimal, and fetor could not be perceived; at the end of the second week, decided improvement with return of appetite was observed; the fourth week witnessed further progress; and at the end of the fifth week the patient was out of bed. During convalescence bits of gangrenous lung tissue were discharged through the external opening.

With reference to the *technique* of the operation, Dr. Fenger recommends:—

1. The incision ought to be made parallel to the ribs.

2. The ribs must be excised to a degree sufficient to secure access to the part.

3. In conformity with the suggestion of Albert and Mosler, the needle of a hypodermic syringe should be used as a guide into the cavity, or diseased lung tissue, and the small platinum pole of Paquelin's thermo-cautery should be employed to effect the opening.

4. The cavity must be washed out if practicable. Due care must be exercised to prevent drowning, if the cavity connects with a bronchus. Irrigation of the cavity was productive of no untoward effect in Buhl's case, but was the cause of troublesome cough in Fenger's patient, and Mosler ascribes one death to poisoning from thymol irrigation.

Dr. Fenger is of the opinion that there is no danger of death from the operation, and that it is indicated in cases of acute, circumscribed, pulmonary gangrene.—*Chicago Med. Four. and Examiner.*

From the various sources of information now available, chiefly clinical, we learn that the preparations of gold possess those properties formerly entitled *alterative*, and now usually designated by the phrase *promoting tissue metamorphosis, or metabolism*, and the power to give stability to nervous matter, or the antispasmodic property. There are three several heads under which it will be convenient to group, for my purpose, the therapeutical powers of gold and its preparations, quite irrespective of its supposed physiological actions:

The so-called alterant effects;

The action on the nervous system;

The urino-genital properties.

Before undertaking to present the details under these several heads, it may be best to say something of the preparation used. I have always preferred the double chloride of gold and sodium, since I learned how little diffusible the chloride is. Injected subcutaneously in animals, the chloride seems not to diffuse through the vessel-walls, and when introduced into the blood tends to clog the kidneys. On the other hand, the double salt is readily diffusible. I have no experience with metallic gold or the oxide. Notwithstanding the chloride is so little diffusible, when taken into the stomach, effects are produced. It is probable that in the reactions which ensue the double chloride—of gold and sodium—is formed.

The usual dose of the gold and sodium chloride is one-twentieth of a grain. In this quantity twice or three times a day, it appears to have, as its primary action, the power to promote constructive metamorphosis, to improve the globular richness of the blood, and to increase tissue strength. However, kept up for a time, tissue changes become more rapid, and waste occurs in excess of repair. The tissues yielding most readily are, as might be expected, the connective, and especially those of pathological formation. Hence the utility of this remedy in *sclerosis*, whether nervous, hepatic, or renal. Especially in posterior spinal sclerosis, and in chronic interstitial nephritis, have I found the gold salt very efficacious. I am far from believing that lost parts may be restored, although some of my critics appear to think my credulity limitless. If used in locomotor ataxia, early and persistently, it has seemed to arrest the disease. It is true, since the publication of Strumpf's results with the faradic brush, I have not failed to make use of this method, but that it alone will stay the morbid process, I do not find. Before the electric brush had been employed systematically, I had witnessed the best results from gold and sodium chloride. During the last ten years, I have seen many cases in consultation, but of five in my immediate charge which I have followed, and in which the treatment was begun with the onset of the second stage, in three the disease seems not only to be arrested, but the condition improved. The knee-jerk, how-

## THE USE OF CHLORIDE OF GOLD.

Dr. Bartholow, (*Med. News*), Aug. 2nd, 1884, says:

ever, remains absent or feeble. The others are manifestly improved. Thus far, no persistent gastric or intestinal disorder has been caused by the remedy.

Excellent results have followed the use of the gold chloride in many cases of fibroid kidney, not only in my own hands, but in the care of other practitioners. Unquestionably the homœopaths, guided in the use of this agent by the symptom—increased urinary flow, have had good results from the first dilution, but this topic is foreign to my present purpose.

There is a form of hypochondriasis, coincident with the onset of degenerative changes in the cerebral vessels—and it may be dependent on these changes, in which the gold and sodium chloride is very effective. It must be persistently used, and after a time the uneasiness in the head, the vertiginous and other abnormal sensations subside, the mental depression at the same time clearing up. Dr. Bauduy, of St. Louis, kindly informs me that he has had the same good effects. It seems to me that the ancient notion that gold is a "cordial" to the mind in the cases of melancholy, is also supported by modern experience.

In certain affections characterized by spasm, as asthma, laryngismus stridulus and singultus, this remedy acts surprisingly well sometimes. A physician with large experience in a malady which I do not see at all nowadays—pseudo-croup, or laryngismus—informs me that he employs no other remedy, and his patients get speedy relief. There are various cognate affections in which, no doubt, it will be found in a high degree useful.

The same powers render gold a remedy of great value in certain urino-genital affections. I have referred to chronic interstitial nephritis. I could enumerate many instances of the more chronic cases of albuminuria, in which the curative effects of this remedy have been most conspicuous; but I am here concerned with the merely nervous affections. There are certain cases of sexual debility, accompanied by an extreme degree of hypochondriasis, which are amongst the most difficult and unsatisfactory with which we have to deal. No remedy has seemed to me so serviceable as this in this troublesome condition of things. In simple sexual debility, its administration promotes activity. In dysmenorrhœa with scanty menstruation, and in chronic metritis, accompanied by these symptoms, the persistent administration of gold and sodium chloride has done much good.

#### LITHOTOMY—LATERAL *vs.* HIGH OPERATION.

Sir Henry Thomson, in his lectures before the College of Surgeons, speaks of these two operations as follows :

There is unquestionably a growing expression of dissatisfaction among surgeons, especially abroad with the lateral operation for stones of unusually large size. I have for some time fully shared that feeling. No incisions can be made in the region which belongs to that operation through which a calculus of three ounces or more can be extracted. Laceration, either avowedly made by instruments or but half concealed under the name of gradual distention, invariably takes place, and that affecting very important structures, often to a large extent. Hence it is that the suprapubic operation has always invited consideration when the stone is exceptionally large; but the conditions sometimes met with, especially in corpulent subjects, have often presented peculiar difficulties and dangers, which indicated that, if Scylla has been avoided above, Charybdis appears to be equally dangerous below. A modification of the operation, however, has recently taken place—if not originated, at least first executed, by Professor Peterson, of Kiel, and described by him in 1880, which gives a new and improved position to the high operation. The improvement suggested consists in ensuring, to a degree not before attained, the raising of the bladder above the pubic symphysis, and the steadying of it in that position during the operation. These objects are thus attained. The patient, lying on his back, and under the influence of an anæsthetic, the bladder is first distended with weak solution of boracic acid, in quantity from ten to twelve ounces if possible, which must depend on the condition of the organ. The penis is firmly tied; nothing is better than an india-rubber tube for the purpose. Then a pear-shaped bag of india-rubber, tolerably stout, so as to retain that form, and capable of holding at least sixteen ounces of fluid, is folded longitudinally and introduced into the rectum. By the tube which forms its apex, and is supplied with a stopcock, water is forced in so as fully to distend the bag *in situ*. The outline of the bladder will now be traced above the pubic symphysis. The usual vertical incision is made, and dissection carried down to the bladder, with the usual precautions with which we are familiar. The ease and certainty, however, which are ensured by the firm position of the bladder on this system render it much superior to the old one.

I have operated by the high operation twice only, and that before the introduction of the new method. Since that time I have met with no case which I have not been able to deal with satisfactorily by lithotripsy at a single sitting, of which several examples are placed before you—the calculi weighing from one to nearly three ounces. The next case which offers for which the knife is required, I shall almost certainly submit to the high operation, with Peterson's modification. And the only reason why I have not yet performed it is, that I have easily and successfully employed

lithotrity in cases precisely similar to those for which the French surgeons are adopting Peterson's procedure.—*British Medical Journal*.

**CEREBRAL ABSCESS.**—The antiseptic method of operating and after-treatment has not yet been fully tested in operations upon the brain. This is natural, for not only have we inherited a just dread of dealing with an organ, the large majority of whose diseases are dangerous or fatal, but our knowledge of the physiological functions of the brain and of their pathological modifications being extremely limited, we are not in a position to form such an accurate diagnosis as calls for surgical interference. Drs. Christian Fenger and E. W. Lee, of Chicago, in an extremely interesting paper on this subject in the July number of the *Am. Jour. Med. Sciences*, consider the treatment of traumatic cerebral abscess, and report a case which was successfully treated by opening and drainage.

Bergman, in discussing the treatment of cerebral abscess, unhesitatingly sets it down as an axiom that wherever there is an accumulation of pus, trephining is most clearly and indubitably indicated, for the opening of an abscess in the brain is as necessary as in any other part of the body, and we would add even more so. A correct diagnosis of abscess having been made, the further difficulty presents itself of locating it with sufficient accuracy, so as to be able to find it. A number of cases are on record in which a correct diagnosis had been made, the trephine also put on more or less on the right place, but the knife or trocar being passed into the brain nevertheless missed the abscess. Drs. Fenger and Lee show by their case that this difficulty can be obviated by multiple exploratory aspirations, performed at interstices sufficiently small to prevent any abscess from escaping detection, even if the trephine opening should not have been made at the point of the skull nearest the abscess.

There are on record a large number of cases of cerebral abscess in which trephining was performed, pus evacuated, and temporary relief obtained; but later relapse followed, and a fatal termination ensued. It is possible, judging from the success the practice has met with in the treatment of abscesses in other situations, that drainage of the cerebral abscess cavity, with or without washing out, would have saved some of these cases, by preventing the re-accumulation of pus and the continuous infection of the surrounding brain tissue, the acute cedema of which is well known to be, as a rule, the final cause of death. As far as Drs. Fenger and Lee are aware, draining and washing out of cerebral abscess cavities has heretofore not been tried; that it can be effected, and without any detriment to the patient, is shown by their case, the treatment of which they hold strictly conforms to the

rational method of modern surgery in treating abscesses in general; and because of this, and not because their patient recovered, they regard the case as answering affirmatively the question: Is it probable that abscesses in the brain can be treated advantageously on the same principle as abscesses in other parts of the body?—*Louisville Med. News*.

**TREATMENT OF TAPE-WORM.**—In the *Med. Times* of October 11th, 1884, Dr. Bernard Persh writes of the comparative value of the remedies used for the expulsion of the tape-worm. At a western military post a number of the men were troubled with this parasite, the writer being of the number. Turpentine, ether, pomegranate-root, male-fern, kooso, salicylic acid and carbolic acid were tried; and the best results obtained from the use of the last two named. Kooso was given in six drachm doses, suspended in water and followed by one ounce of castor oil. Two grains of carbolic acid were administered in a pill of extract liquorice; if, after a dose of castor oil this treatment failed, it was repeated on the following day. Large doses of carbolic acid may be given without producing disturbance of the digestive organs or carbolic acid poisoning; but in some cases even large doses of the acid failed to expel the worm. Several years after, the writer having been recommended to try croton oil and chloroform as a remedy, did so on himself, and it proved successful where the others had failed. Since that time he has used the treatment on more than twenty cases with excellent results. One drop of croton oil and a drachm of chloroform are suspended in an ounce of glycerine, and administered in the morning before breakfast. The only preparatory treatment consists of a half ounce of Rochelle salts given the preceding evening, which, although not necessary for a cure, facilitates the examination of the evacuations, prevents the breaking of the worm by hard fæces and allows it to pass more quickly through the intestines after becoming detached. The chloroform produces no bad effects; the slight giddiness and drowsiness sometimes noticed was relieved by the recumbent posture and disappeared when the croton oil commenced to operate. The oil acts rapidly, the bowels being moved in about an hour after its administration, and any tendency to diarrhoea or intestinal irritation is readily checked by bismuth and opium after the worm has been expelled. In one case the chloroform alone was efficient in bringing about the expulsion of the worm; but the fact that the worm is always expelled alive, showing that the chloroform, while compelling it to relinquish its hold, is not sufficient to kill it, renders the administration with it of a drastic purgative of rapid action, advisable. The author concludes by stating that in the cases treated successfully in this way, other remedies had been unsuccessfully employed. The patients agreed that

the remedy was readily taken, that its immediate effects were by no means unpleasant, and that the treatment did not leave them prostrated.—*Maryland Med. Journal*.

**GLOSSO-LABIAL PARALYSIS**—Modern thought and research drift more and more to the position that the affection described by Duchenne as glosso-labial paralysis, and long supposed to be distinct, ought to be stricken from the list of diseases. In its typical form it is certainly only a localized chronic poliomyelitis, a mere variety of chronic muscular atrophy, in which the gray portion of the upper segment of the spinal cord—i. e., the medulla oblongata—is especially attacked. It may exist by itself, or it may be associated with symptoms of palsy, due to poliomyelitis, in other parts of the body. In the latter case the medulla may be the first part of the cord invaded, the disease extending downwards, or the lesion may progress upwards and the medulla show the latest change. In a very interesting case recently shown at the clinic of Prof. H. C. Wood, the first symptoms were perceived by the patient in the mouth region, and subsequently the cervical cord became profoundly affected.

To grant these labio-glossal paralyses a separate state in our classification of disease would logically require similar treatment for cases of progressive muscular atrophy in each part of the body, since any spinal region may be attacked alone or separately.

The absurdity of the present separation of glosso-labial palsy is further shown by the circumstance that we may have such paralysis due to various apoplexies, brain-tumours, and other coarse cerebral lesions, and, to be logical, we should also isolate as a distinct disease cerebral glosso-labial paralysis.

In No. 20, *Archives de Neurologie*, is an important paper upon such an affection, by Dr. F. Raymond, in which illustrative cases are cited. The symptoms may, in case the lesion is a tumor, or other progressive alteration of brain-tissue, develop slowly, but they usually come on suddenly, because they are usually the result of clot or other apoplectic lesion, and, while they may develop alone, they are usually associated with other consentaneous palsies. Whether the manifestations come on slowly or rapidly, the cases are to be distinguished from those of medulla-disease by the absence of atrophic changes in the muscles affected, and by the preservation of the normal electrical reactions. The symptoms are stationary or progressive, as the case may be, *pari passu* with the cerebral lesion. The latter is either cortical or in the white matter. The general localization of the lesion of the white matter is in the lenticular nucleus or the external capsule, or sometimes in the internal capsule or peduncle. The foot of the ascend-

ing frontal convolution is stated to be the position in which cortical lesions cause the glosso-labial palsies.—*Medical Times*.

**CHRONIC BRIGHT'S DISEASE.**—Dr. Hiram Corson, Conshohocken, Pa., in a recent communication to the *Medical Times*, says: That a farmer, 46 years of age, complained for several months of ailments not uncommon in the beginning of Bright's disease, and finally sent for a physician, who finding his urine to be very albuminous, put him under the use of the various medicines recommended in that affection. Months passed; the limbs began to swell, and the anasarca was over the whole body. All the usual remedies of the day were applied, but with only the effect of temporary relief at times, to be followed by aggravation of the symptoms. When he was in this deplorable condition I remembered case upon case seen forty or fifty years ago, much like this, and proposed that we try the old plan. So we began to give, in pills, one grain of calomel, one of digitalis, and one of squill, three times a day, morphia or chloral, one or both, at night, to relieve oppression and induce sleep. Day after day we went on for two weeks, before the breath announced that the system was effected by the calomel, and all this time there had been no perceptible change save an increase in quantity of urine. But then all the symptoms showed an amelioration. The medicine was then used or omitted as seemed indicated. The object was to keep the system moderately under the influence of the mercury (what an awful word!) but not to push it to heavy salivation (another awful word!) From that time, every day showed an improvement—a rapid improvement—in the symptoms. Now, that is just what I will do for the first advanced case of Bright's disease that may come under my care.

**HÆMORRHOIDS OPERATED ON WHEN INFLAMED.**—Before the Kentucky State Medical Society at its recent session, held at Bowling Green, Prof. J. M. Mathews, of Louisville, addressing himself to this question, said:

"From a variety of causes, piles are liable to become inflamed, and once inflamed, they may easily become strangulated by passage below the sphincter. Everything is aggravated in this condition and it may take some weeks to quiet the trouble. It has occurred to me, why not operate upon and get rid of them at once? There is no authority that says 'operate upon a pile during the inflamed state,' but they will tell you to apply treatment to reduce the inflammation. I want to state one or two cases. A few weeks ago, I was called to a lawyer who was in this condition. The family physician in attendance had tried in vain to quiet inflammatory action, for two or three weeks. I found, hanging down from the anus, two solid

tumors; I passed the knife around them and ligated them. I visited him the following morning, expecting to find him in some trouble. To my satisfaction, he was out of the house in one week's time. Another case: A young man had a mass of inflamed tumors, hanging from him, larger than my fist. It would have taken several weeks to abate the inflammatory trouble and I ligated the whole mass. I went to see him next morning. I was told by the people at the house, that he had rested well all night, and got up early in the morning and went out. They sent for him but he could not be found. Three days later, I received a postal from Cairo, Illinois, saying that he was that far on his way home and was all right. When he got home he wrote me that he was entirely well; since then, I have had, I suppose, five or six cases of similar character, in which the proceedings and results were similar. I have, therefore, concluded that instead of applying remedies to relieve the inflammation in the tumors, they should be operated on at once."—*Am. Practitioner*.

**THE TREATMENT OF SPRAIN BY THE ELASTIC BANDAGE.**—This method of treating sprains has recently been recommended by Marc See (*Revue de Thérap.*). It is the only method which fulfils the two indications: 1. To cause as rapid absorption as possible of the blood extravasated around the joint (a lesion which controls all the other symptoms, such as pain, swelling, difficulty of movement, etc.); and, 2. To favor cicatrization of the torn ligaments and ruptured parts by complete immobilization.

The antiphlogistics and blood-letting, formerly advised by Hunter and Guersant, only partially fulfil the former indication. There is the same objection to the movements which Ribe and Bonnet advise for the injured joint. The refrigerants and cold-water baths advised by Baudens cause contraction of the tissues around the joint, and dispel inflammation, but they are not favorable to the absorption of the infiltrated fluids. Even massage, though superior to the other remedies just mentioned, fulfils only the second indication; furthermore, it is inconvenient, and requires much patience and time; and between the seances of manipulation the swelling reappears and the pain returns. It is true that massage has the advantage of removing the extravasated materials from the region of the joint toward the more vascular portions of the limb, where they are more easily absorbed. But the elastic bandage has this advantage in a greater degree, since its action is continuous. Finally, and above all, it favors immobilization of the joint, which is impossible during massage, and without which it is almost impossible to get cicatrization of the torn structures and complete recovery in sprains of any intensity. The bandage should be applied to the skin itself, care being taken to fill up the flat

and depressed places with wadding, so as to give a uniform surface around the joint for the bandage to act upon.—*Medical News*.

**CHRYSOPHANIC ACID IN SKIN DISEASES.**—Dr. Stocquart reports sixty-one cases treated by internal administration of chrysophanic acid (*Annales de Derm. et de Syph.*, Jan. 1884). No form of local treatment was employed. Of the sixty-one cases, fifty-six were entirely cured, and only one was unaffected by the treatment. The cases of acne, ecthyma, and impetigo, all yielded rapidly to the treatment, except one case of papulous acne. One case of pityriasis and three of urticaria were also quickly cured. In four cases of lichen and four of prurigo, the irritation was rapidly diminished, disappearing before the complete cessation of the eruption in lichen. Of thirty-two cases of eczema, thirty were cured. The author was struck with the rapid and complete cure of acute eczema and of impetiginous eczema in children. Out of five cases of psoriasis, three were cured. The acid was generally administered in water, the bottle being well shaken before use. In ordinary doses no patient objected to it; it was also prescribed in pills. The medium dose is one centigramme a day for children, and three centigrammes for adults. In these doses it is generally well tolerated; in large doses it may cause loss of appetite, nausea, palpitation, with præcordial distress and constriction of epigastrium, giddiness, vomiting, and cold shivers. This is an occasional occurrence only, and often much larger doses are well borne. Children tolerate the medicine well; at four weeks, he has given one, two, and in one case five centigrammes without provoking gastric irritation. Where the eruption is limited to parts ordinarily covered, and when the skin is not very thin or delicate, the external use of chrysophanic acid as an ointment is indicated. Where a great extent of surface is involved, the internal use is better. Phenomena of local irritation, or erysipelas, or gastro-enteric symptoms, or nephritis, may be caused by the too free external use of the acid. Its internal use is also indicated when the eruption affects the hands or face. Where the stomach will not bear the remedy, it may be given hypodermically; but is then apt to cause pain and abscess. Its action is more rapid than when given by the mouth.—*N. Y. Med. Jour.*

**A MEDIEVAL RELIC.**—At the recent meeting of the American Gynecological Association, Dr. T. Gaillard Thomas showed and made some interesting remarks about a medieval relic which had recently come into his possession. He had spent the past summer in a little, out-of-the-way Long Island village.

A friend in this village had recently received as a bequest, from France, some thirty large, old-fashioned trunks. These trunks contained old



MSS., books, jewelry, dresses, and odds and ends of all descriptions. In one of the trunks a very peculiar harness, which puzzled the gentleman, was found. It was submitted to Dr. Thomas. Upon examination, it was found to consist of a jointed steel girdle, covered with velvet—intended to encircle the waist of the wearer—and a semicircular rod of solid steel, with two circumscribed dilations, joining the circular girdle at right angles. It was evidently meant to be employed in the same way, though for a different purpose, as the female T bandage. The diamond-shaped dilatation, intended to fit accurately the vulvar orifice, was guarded upon both sides, on the inner edge with sharp steel teeth, pointing downward, forward, and outward. The circular ring designed for the anal orifice was provided with steel teeth in an identical manner. Armorial bearings were discovered upon different portions of the harness. Behind, at the point of junction of the girdle with the perineal rod, was the place for a lock, or rather seal. The diagnosis was plain. It was a *ceinture*, similar in shape and design to the girdle of *Diana de Poitiers*, which every one who visits Paris sees in the *Musée de Cluny*. The Crusaders were evidently in the habit of locking up home effects before their departure to the wars.—*Louisville Med. News*.

**CANCER OF THE CERVIX UTERI.**—Dr. Goodell gives the following method of treatment in the *Med. and Surgical Reporter*—"Having torn away all I can with my fingers, I inject pure vinegar, and now resort to the serrated curettes. With these the parts are thoroughly scraped, and with the gouge-forceps the vaginal portion of the cervix is removed. Next, with the platinum buttons of the thermo-cautery, I char the whole funnel-shaped wound. \* \* \* The operation is now ended, and as there is no hemorrhage, I shall not tampon the vagina. But supposing you operate in the country at a distance from home, and you wish to guard against hemorrhage, or to stop an oozing, what do you do? You take a sponge and pass a string through the centre and tie the two free ends together in a long loop. Do not tie your string around your sponge, for you will then deprive it of its elasticity and the power of expanding. Prepare three sponges in this way, and soak them in vinegar. Pack the first sponge very firmly into the funnel-shaped wound, and make one knot in its string. The second sponge, with two knots in its string, will be pushed down to the cervix; and the third one, with three knots, will keep the other two in place. In twenty-four hours remove the sponge with three knots, and in forty-eight hours withdraw the sponge with two knots, and immediately afterwards the sponge with one knot. This last one must be removed carefully, and with a rotary motion. I do not put sponges in my patient's vagina

because she is in a hospital, in which some physician is always on hand. But supposing at 3 o'clock this afternoon the nurse finds our patient bleeding, what instructions shall I give our resident? He will first inject vinegar, and if that does not stop the hemorrhage, he will then pack the womb and vagina with sponges in the way which I have just described."

**THE MEDICINES PHYSICIANS USE.**—Squibb's *Ephemeris* gives an analysis, containing some points of interest of some observations made by Dr. Wm. P. Bolles on the prescriptions which he found on the files of three Boston pharmacists. The number counted was 3,726 which were pretty generally from physicians of that city. The number of articles entering these prescriptions was 504, the whole number contained in the U. S. P. for 1880 being 994. Of the 504, 236 occurred 5 or more times; 157, 10 times; 80, 25 times; 27, 50 times 9, 100 times; 1, 200 times. Sulphate of quinine leads the list, and is found in 292 of the 3,726 prescriptions; sulphate of morphine in 172; bromide of potassium in 171; iodide of potassium in 155; tincture of chloride of iron, 134; subnitrate of bismuth, 133; glycerine and syrup together, 120; syrup, 108; carbolic acid, 92; extract nux vomica, 87; paregoric, 80; bicarbonate of soda, 77; calomel, 72; chlorate of potassium, 71; compound tincture of gentian, 67; lime water, 65; and so on down. It will thus be seen that of the 994 articles of the *Pharmacopœia*, only 18 occur more than 65 times in 3,726 prescriptions, and of these 18 three are vehicles or adjuncts which are in such common use as to bring their numbers into prominence. Dr. Squibb regards it as surplusage of a very useless kind to have a drug in substance, in *abstract decoction, infusion, extract, fluid extract, and tincture*. He says the individual habits of physicians are the cause of much of this surplusage. One of the remedies for this evil he points out as follows:—"The individual preferences of physicians are largely prejudices adopted from teachers in the schools, and, therefore, if the schools would but reason upon the subject, and direct only the best preparation of each drug, a needed reform in the *Pharmacopœia* would soon follow, and the pharmacists' supplies would be much fresher and more trustworthy.—*Med. Age*."

**PLACENTA PRÆVIA.**—Prof. Parvin (*Col. & Clin. Record*) says:—"While there is no single plan of treatment applicable to all cases of placenta prævia, in general, this treatment may be comprehended in the alliterative phrase, Temporize, tampon, turn. Temporize if the hemorrhage be not so great, and the pregnancy not near its end. Tampon if the hemorrhage be severe, and the os not sufficiently dilated for immediate delivery; but let the tampon be so applied that the hemorrhage will



be surely stopped and that dilatation of the os may be effected. Of course, a tampon can be most effectually applied if the perineum be drawn back by a Sims' speculum, and the os can be best dilated by a sponge-tent, or by means of Barnes' dilators, and these are to be preferred. If you use a vaginal tampon, do not soak the material in any astringent solution, for it is not by coagulating blood, but by pressure, you hope to arrest the flow. Of course, position is important, and you may also give cold acid drinks; opium and stimulants may be required if there be pain and prostration. Finally, turn—turn, because very often in placenta prævia the foetus is transverse; turn, because when you bring the legs and then the thighs into the os uteri, you have a most effectual tampon; turn, because you can thus as a rule most quickly effect delivery; and the great dominating principle in the treatment of placenta prævia is, that when the hemorrhage is grave, end the pregnancy as soon as possible, both for the safety of the mother, and the safety of the child.

**MORPHINE IN THE EARLY STAGES OF INSANITY.**—The responsibility of the physician in the use of morphia, in consequence of the possible development of the morphia habit, is great; but his responsibility relative to the possible disaster of a preventable life-long insanity, not prevented, is, if possible, still greater.

Auguste Voisin, of the *Salpêtrière*, Paris, claims for the use of the hydrochlorate of morphia, in gradually increased large doses long maintained, remarkable results in the treatment of certain forms of insanity. His theories are well sustained by physiological observations, and his cases are taken from the records of the *Salpêtrière* and private practice, and many of the cases have been examined after the lapse of several years.

In the article referred to, "Leçon Trentième," he gives a resumé of the history of the systematic use of opium and morphia in the treatment of insanity, and dates his own experience with it from the year 1867. His success was at first greatly diminished by the obstinate vomiting which frequently occurs; but on learning from M. Roller, Physician of the Insane Asylum at Illenau, France, that, regardless of the vomiting, the dose should be increased, he continued to increase the dose, and to that instruction he attributes his success. He has since treated successfully the various manifestations of insanity, which would seem to correspond practically to the first division adopted by the International Congress of Alienists in 1867, namely: simple insanity, comprehending mania, melancholia, monomania, circular insanity, moral insanity, in their early manifestations.

He uses exclusively the hydrochlorate of morphia, and only hypodermically, but fails to give the strength of the solution which he finds most

satisfactory. He does not mention the combination, so much appreciated in America, of morphia and atropia. Probably the association of the atropia is not to be desired. The efficacious dose desirable to sustain until the desired effect is obtained, can only be found by proceeding cautiously and studying each individual apart. One rule which the author never departs from, is not to exceed, in the initial dose, from one to three milligrammes. Whilst light cases associated with hallucinations are frequently relieved in a few days with a daily dose of from five to six centigrammes, yet in other cases the dose has to be increased to seventy centigrammes. He narrates one case in which two grammes of the hydrochlorate of morphia, in two doses, were administered daily, with no manifestation of its presence beyond a contraction of the pupils. The latter was one of the unsuccessful cases. He never entrusts the administration to a nurse.—*Four. Am. Med. Assoc.*

**IS PAIN DURING THE FIRST STAGES OF LABOR NECESSARY?**—In a communication to the *Obstetric Gazette*, Dr. I. W. Chisholm says that in answering this question I would say, from my own experience, and also from the observation of others with whom I have conversed on the subject, I have concluded that the pains incident to dilatation of the os during the first stage of labor are not necessary. My attention was first directed to this some years ago. Being called to see Mrs. G., whom I found suffering from the pains of the first stage of labor, being of the grinding character, and seemingly at regular intervals, I found, upon examination a rigid os and no signs of dilatation, and after waiting a considerable while I made another examination and found the same condition of things. I then concluded the pains were probably of the spurious kind, despite their seeming regularity, and gave her a dose of morphia, and in a short time she was entirely relieved and I took my departure. About ten o'clock in the evening I concluded I would call and see her before retiring, and on entering I found her resting comfortably, as she had been ever since I left in the morning after administering the morphia. I made an examination and found the os well dilated. I remained, and in a short time the second stage of labor came on, and the child was born in a few hours.

I was attending on Dr. P. at that time, and on calling on him in the morning I reported the results of my observations, he being a man of a large and extended experience of thirty-five years, said that he also had noticed the same thing, and always attended by good recoveries. Now if this is the experience of all who have tried it, why not relieve women of the painful ordeal of the first stage of labor?

A PIN SLING.—Samson Gamgee F.R.S.E., of

Birmingham, gives the following in the *Lancet*, Sept. 27th, 1884: A gentleman consulted me the other day, for a painful condition of the tip of his left little finger. To secure the benefits of physiological position and immobility, I bent the elbow at an acute angle and raised the hand; then, pinching up the sleeve at the wrist, fixed it to the coat with a safety-pin; with another I attached a fold of the sleeve to the coat just under the elbow. Rest was absolute; the finger waxed pale and easy; and my patient went to his office duties in comparative comfort.

Even if an ordinary sling be at hand, the process of fixing the forearm at an acute angle is not quite simple; and the resulting unsightliness is often unpleasant. With a little contrivance a pin sling may be made invisible. A third pin, fixing the inside of the arm sleeve to the body of the coat, adds greatly to immobility. In this position I have found one pin very useful, in steadying the shoulder of a young lady who had had it dislocated three times. She had barely recovered the last accident, when she was very anxious to go to a ball. By fixing, with a safety-pin, the inside of the sleeve to the bodice, a trusty yet invisible, checkmate was provided, allowing freedom of hand, but barring abduction. These are trifles, only noted apologetically, because, *pro re nata*, they may be useful.

CHLORATE OF POTASH IN TINEA.—Dr. C. C. P. Clark once had a case of tinea tarsi in a little girl. In spite of all the treatment recommended in the books, the morbid condition of the Meibomian glands persisted in pouring out their sticky exudation. Considering its efficacy when internally exhibited as an alterative in certain affections of the mucous membranes, particularly of the mouth and throat, the patient was given full doses of this medicine—about a drachm per diem. It worked like a charm. Repeatedly the disease returned, as is its wont, and was as often and as readily subdued. He has since constantly used this medicine in that complaint, and has never been disappointed.

Not long after a lad was brought to the doctor whose scalp was thickly bossed with huge, stinking, porriginous scabs. Reasoning from what was seen in the last-mentioned case, the same remedy was used to stay the morbid secretion in this, and with like good effect. The crusty hummocks disappeared, as a syphilitic node sometimes will under the use of the iodide of potassium, only far more rapidly. He who tries this remedy in this disease, in full doses, will not turn again to the scalp-shaving, poulticing, etc., which is the customary practice.—*N. Y. Medical Journal*.

THE HYPODERMIC INJECTION OF PILES.—Dr. J. W. Girard, of Winchester, Tenn., says "that the use of carbolic acid in hemorrhoids is condemned by the majority of leading physicians, but

successfully used by non-professional men." He further asks if there is not something radically wrong in the method of using the remedy, or in the act of condemning it, and continues: "If my experience with the use of the hypodermic syringe in hemorrhoids is worth anything to the profession I give it cheerfully.

"I have used it for about ten years, and have treated, I think, about two hundred cases without a single failure, and in no case has the tumor returned thus far. My course of treatment is generally to take one part of tannic acid, two parts of carbolic acid, four parts of alcohol, and eight parts glycerine. Inject each pile separately, and in a few days they slough away and generally heal kindly under dressings of carbolated cerate. If there is much constitutional disturbance, I generally control it with a steam bath or a hot sitz bath. My confidence in the method is so strong that I would persist in its use in spite of all that could be said against it. I would gladly answer any questions in my power that would enlighten any professional brother on the subject."—*Medical Bulletin*.

"TAKE YOUR FORCEPS WITH YOU."—Dr. H. V. Sweringen, of Fort Wayne, Ind. (who is well-known to our readers), contributes an article with this caption to the July number of the *Obstetric Gazette*, for the purpose of warning all physicians to be very particular always to carry with them to every labor case their forceps. It is well to issue such a warning occasionally, because on account of the very large proportion of cases of parturition that terminate spontaneously, the physician is very apt to leave his forceps at home, feeling that the chances are against his being obliged to use them, and if his home is far from his patient, and the demand for instrumental interference becomes very urgent, the patient may die before the forceps can be procured. Such a case has happened to Dr. S., and he concludes his article by saying, "I verily believe, that if she had been delivered promptly, with the forceps, immediately upon or before the appearance of her first convulsion, her life would have been saved. I close as I began, *take your forceps with you always*."—*Med. & Surg. Reporter*.

TREATMENT OF NASAL POLYPI.—As a valuable contribution to the therapeutics of this unpleasant condition, we are glad to note that Dr. Richardson, in the *Asclepiad*, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. This cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient

can expel the whole mass of destroyed polypus, in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Ibid.*

**USES OF MURIATE OF AMMONIA.**—The *Med. Record* says: It increase the secretion of mucous from the alimentary canal, and is supposed to render the blood less plastic and coagulable, without impairing the structure of the corpuscles. Its habitual use causes emaciation, renders all the secretions freer and more abundant, and exerts an alterative and absorbent action, especially on the connective tissues, in hyperplasia and cirrhosis of many organs. It has even exerted some beneficial influence upon fibrous tumors of the uterus, and much more upon chronic engorgement of that organ. Its slow but steady modification of the nutrition of the connective tissues has been seen in chronic enlargements of the liver, spleen, prostate, thyroid and other enlargements. It cures many cases of gleet and if any internal remedy will relieve strictures of the urethra, this is the one most apt to do it. It cures some cases of neuralgia depending upon thickening of the neuilemma, and is one of the best remedies in fibrous phthisis. If other remedies fail, it should be tried in sclerosis of the cord and brain depending upon thickening and induration of the neuroglia.

**MEMBRANOUS CROUP.**—Dr. Jacobi says (*Med. News*) the mercurial treatment of membranous croup promises good results. The bichloride appears to be the best preparation for this purpose. The remedy should be given early and frequently repeated. The bichloride should be well diluted (about 1 to 3000). To babies about half a grain should be given in twenty-four hours, and, as a rule, its administration could be kept up for many days, if necessary, without bad effects. Stomatitis or salivation is very rarely observed, and gastrointestinal disturbances are not frequent under its use. If any unpleasant consequences result from the bichloride, inunction by the oleate of mercury is advised in its place. If the treatment of the diphtheritic disease be undertaken in time, the croup may often be prevented, as this is believed to be due to descending pharyngeal diphtheria.

**HYSTERIA WITH UNILATERAL SWELLING.**—Dr. S. Weir Mitchell records in the July number of *The Amer. Journal of the Medical Sciences* three cases of hysteria in which there was unilateral in-

crease in bulk at or near the menstrual period, and also at other seasons after emotional excitement, and he has been unable to find elsewhere any narration of similar cases. The writer cannot explain the causes of this phenomenon further than to say that they are under the influence of the nervous system, and vary with the causes which also increase or lessen the analgesia or give rise to chronic spasm. Most probably, he thinks, in many unilateral hysteric palsies a like phenomenon exists, and has merely escaped attention because of being the least prominent in a group of symptoms. At all events it adds another to the large group of resemblances which so closely relate organic to hysteric hemipalsy.—*Boston Med. Journal.*

**BLISTERS AND SALICYLIC ACID IN RHEUMATISM.**—The following are a couple of brief extracts from a clinical lecture delivered by Prof. Draper at the New York Hospital (*Med. & Surg. Rep.*):

Now a word about the use of blisters in the treatment of inflammatory rheumatism. We do not very often resort to them in acute cases of inflammatory rheumatism where there is a high temperature and great tenderness and swelling of the joints. And in my experience, they are not nearly so valuable here as in cases of sub-acute rheumatism. But where they are used in the very acute cases, it is almost invariably in connection with some other anti-rheumatic treatment, so that we do not get, I think, a true estimate of their value. But in those sub-acute cases where there is a moderate amount of infusion into the synovial cavities and some thickening of the tissues surrounding the joints, I believe that rest of the part and the local application of a blister are very valuable—while in cases of acute inflammation of the joints, I do not believe that blood-letting and counter-irritation are of much value.

There is one remark I wish to make about the salicylic acid treatment of rheumatism. I have told you before that of all the remedies which have been suggested for the cure of rheumatism, and their name is legion, none have given such satisfactory results or proven so valuable as salicylic acid. Now the history of the treatment of rheumatism constitutes a very remarkable chapter in the history of therapeutics.

There is no disease for which a greater diversity of remedies has been proposed. At one time acids were in favor, and at another time alkalies; at one time purgation was practised, and at another opium was used; and salts of every variety have at different times been supposed to have some superiority in the treatment of this disease. As a result, skeptics have arisen who doubt the efficacy of any treatment at all in rheumatism. So about fifteen years ago, at the time of the introduction of Fuller's alkaline treatment, Drs. Gull and Sutton treated a number of cases with simple mint-water, and their

results were as good as were obtained with the alkalis. They believed that all cases ran a regular course, and all had a tendency to end in a week or nine days, or in a fort-night, or else in the classical period of six weeks. But when you come to the salicylic acid treatment, there is no question as to its power. When you see, as we frequently do here, the greatest relief produced within twenty-four hours by the administration of ten-grain doses every two hours, and you find at the same time a great improvement in the appearance of the joints, I think that we get here not only a "post hoc" but a "propter hoc" argument to justify us in attributing the improvement to the use of salicylic acid.

**OSTEOTOMY FOR GENU VALGUM.**—Osteotomy for genu valgum was discussed at the International Medical Congress, and Macewen's supracondyloid osteotomy was acknowledged by all to be the most satisfactory one. Professor Ogston gracefully acknowledged that his own operation (fracture of the internal condyle) did not yield as good results as Macewen's simpler and safer operation. Professor Schede said that, with German surgeons, he had accepted Macewen's operation as the best. He differed from Dr. Macewen in doing his operation in one respect—he did not use but one chisel, and considered the withdrawal of the instrument from the wound a serious matter, in that it led to an unnecessary disturbance of the parts, and frequently some difficulty occurred in reintroducing the chisel. He thought that in many cases the tibia, rather than the femur, was involved, and in these cases he preferred his own operation (section of the tibia). Mr. Bryant complimented the gentlemen on the manner in which they had given up their pet operations, and had accorded to the supracondyloid operation (Macewen's) its just value.

**INTRA-CAPSULAR FRACTURE OF THE FEMUR.**—Dr. W. M. Fuqua is of the opinion that the "do nothing" plan of the older surgeons, in these cases, is wrong, and should be abandoned. Experience has shown that bony union can be had, and he thinks that every effort should be made to bring it about. He is satisfied that many of these fractures are through the inter-trochanteric lines, and therefore amenable to the reproductive influence of the periosteum. In the *American Practitioner* for October, 1884, he relates a case where, after ten or fifteen days' confinement to bed, he adjusted a well-fitting "*Sayre's short splint*," and placed the patient on his feet, having first lengthened the sound leg by the addition of an inch cork sole. With this appliance, and a crutch and cane, the patient walks about just as in a case of chronic disease of the coxo-femoral articulation. If the tendency to eversion, or possibly to inversion, be great, then "*Sayre's long splint*" would be required, night extension to be made by weight, and the

splint to be used during the day.—*Med. and Surg. Reporter.*

**REDUCTION OF SUBCORACOID DISLOCATIONS.**—Reduction of subcoracoid dislocations, as directed by Kocher, is accomplished as follows: Patient, sitting up, the forearm is fixed to a right angle with the arm, the elbow pressed firmly to the side of the chest; the arm rotated outward until firm resistance is met with; then the arm rotated inward. The last movement is one of restitution, and carries the shoulder opposite the one dislocated. These manipulations resolve themselves practically into two movements—outward rotation and flexion. Dr. C. A. Jersey (*New York Medical Jour.*, December 8, 1883) says the advantages of the method are:

1. The control obtained over the humerus by the position of the forearm.
2. The advantage obtained by the relaxation of the edges of the rent in the capsular ligament.
3. The absence of the necessity for the employment of an anesthetic.
4. The absence of pain to the patient and of discomfort to both surgeon and patient as compared with other methods.—*Medical Herald.*

**TREATMENT OF BOILS.**—Dr. John Aulde, following the suggestions of Dr. Sidney Ringer, has met with most satisfactory results by adopting the following plan. The diet is to be regulated and if constipation exists, a teaspoonful of magnesia sulph. in a glass of cold water should be taken every morning before breakfast:

R. Calcii sulphidi . . . . . grs. iij.  
Sacch. lactis . . . . . grs. xxx.  
Misce bene et div. in chart., No. xxx.

Sig. Five powders daily at intervals, between meals.

By this method beginning boils will be aborted, and those far enough advanced to threaten a siege of several weeks and successive crops, will soften and heal in such short time that the patient will be surprised at the result. When they can be obtained, granules containing one-tenth grain are to be preferred to the powders. The urine should be examined for sugar, as boils and diabetes often go together.—*Summary.*

**GUMMA OF THE BREAST.**—Prof. S. W. Gross, says the *Medical Bulletin* (August), brought a case of gumma of the breast before the class last season, which was interesting, both because of the infrequency of its occurrence, and of its resemblance to malignant disease. Gumma of other parts of the body are met with almost every day in hospital practice, but it is extremely uncommon to find this manifestation of the syphilitic poison on the female breast. The patient, who was twenty-eight years old, and appeared to be in good health, complained

of trouble in the left breast. Examination showed a cake-like superficial tumor, involving the skin and subcutaneous connective tissue. The skin over the tumor was livid in color, and the nipple was retracted into it. These signs apparently pointed to superficial scirrhus. But from the absence of pain and axillary involvement, as well as the history of a dissolute husband and three miscarriages, Professor Gross concluded that it was a gumma. The woman was put on the mixed specific treatment, and the tumor disappeared in a short time.

**LIVER SPOTS.**—In an article on tinea versicolor, or liver spots, the *Med. and Surg. Reporter* says: The treatment is not difficult. The sulphur preparations are all useful, such as sodium hyposulphite, one drachm to the ounce of water, or Velminckx's solution, which is prepared as follows: Quicklime, one half ounce; flowers of sulphur, one ounce; water, ten ounces. Boil down to six ounces and filter. Perfume with oil of anise. This may be used diluted with four to eight parts of water, to be dabbed on the patches after a bath with soap and water. At the end of a week scarcely any sign of the disease will remain, and at the end of two weeks a cure may be effected. The result depends largely on the manner of making the application.

**EXTIRPATION OF GOITRE BY MEANS OF THE ELASTIC LIGATURE.**—Dr. S. Usiglio (*Gaz de Asp*), reports the case of a patient, æt. 56, who had enlargement of the thyroid body due to hyperplasia of the left lobe, in which the enlargement was removed by means of the elastic ligature. The part came away in five days and the patient recovered easily. Two months previously, in March, 1883, Dr. G. B. Masta had successfully employed the same means for the removal of a pedunculated tumor. De Vecchi and Castelleone have also reported cases. An incision is made into the skin in which the ligature is placed, the wound being disinfected and the ligature tightened daily.—*Practitioner*.

**IN-GROWING NAIL.**—In a note to the *Union Medica*, June 26, M. Monod states that during the last twenty years he has treated in-growing nails by a very simple and effectual method, which does not involve the removal of the nail. He makes a free application of nitrate of silver at the commencement of the affection, without isolating the nail. If the cauterization is carried deeply into the diseased furrow, the patient has usually, even by the next day, derived considerable relief, and is able, even thus early, to walk in moderation with an easy shoe. Extirpation of the nail should be reserved for quite exceptional cases.—*Kansas City Medical Record*.

**POSITION IN THE AFTER-TREATMENT OF LITHOTOMY.**—Alex. Faulkner, of H. M. Indian Med. Service, says:

"I should like to bring to notice a point in the treatment of cases subsequent to the operation of lateral lithotomy, which I have practised for some time, namely, the advisability of continually keeping the patient lying on his abdomen after the operation. Although this mere position may seem at first an apparently trivial detail, yet I consider it is of importance in expediting the healing process of the perineal wound, as by its means the urine has a tendency to pass more through its natural course into the urethra when expelled from the bladder, instead of continually permeating through, and, consequently, irritating the open perineal wound."—*Med. Review*.

**DR. J. A. LARRABEE**, Prof. of Diseases of Children and Materia Medica and Therapeutics, Hospital College of Medicine, Louisville, Kentucky, says: Bromidia I regard as a more elegant and acceptable mode of administering safe and effectual hypnotics in childhood, than extemporaneous prescriptions. I have no doubt that Bromidia has supplied a want felt by many practitioners in diseases of infancy and childhood, preventing many from yielding to the temptation to use the various preparations of opium, which are so objectionable and dangerous.

**INTESTINAL HEMORRHAGE IN TYPHOID FEVER.**—At a recent clinical lecture, Professor Da Costa exhibited specimens from a case of typhoid fever in which death had occurred from peritonitis, with three recent perforations of the bowel. The patient four days before his death had had a profuse intestinal hemorrhage. The distinguished teacher took the opportunity of endorsing the ergot treatment of the hemorrhage, but insisted upon the importance of following it up with decided doses of opium in order to prevent perforation or to limit its effects.

#### OLEATE OF BISMUTH IN ECZEMA.—

R Bismuthi oxid,	. . . . .	3 j.
Acidi Oleici,	. . . . .	3 j.
Ceræ albæ,	. . . . .	3 iij.
Vaseline,	. . . . .	3 ix.
Ol. rosæ	. . . . .	m ij. M.

Its action is particularly satisfactory in eczema of the hands.—*Von Harlingen in Philadelphia Medical Times*.

A medical student gave the following translation of the very correct Latin adage: "De mortuis nil nisi bonum": "From the dead nothing but bones." He was, probably, cousin-German to the young man who, in answer to a question declared Virchow to be the discoverer of vaccination.

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## THE PAST YEAR.

As is our custom at this season of the year we present our readers with a short *resumé* of the progress of medicine and some of the principal events which have transpired in the medical world during the past year. This we find, from the wide scope of the work, even in the necessarily imperfect manner in which it is done, to be no easy task. and we would gladly be relieved from the labor if we had the slightest reason to believe that it was not appreciated by the majority of our readers. The ceaseless activity in all departments of medicine renders it very difficult to follow with a critical eye all the new theories, methods, and appliances which have been advanced by enthusiastic admirers, yet there are a few prominent features connected with the progress of medicine, surgery, obstetrics and gynecology which it may be well to call attention to. Of all departments of medicine probably none have made more rapid strides than public hygiene. The subject is being continually pressed upon the attention of the governments both at home and abroad. Sanitary associations are being formed under favorable auspices, sanitary laws enacted, and governmental aid granted for the purpose of advancing the spread of knowledge among the people on subjects of the highest importance to their well-being. At no period in the world's history has greater attention been paid to sanitary science than at the present time. All this is the outcome of the teachings and repeated admonitions of the medical

profession, which is ever in the vanguard of all mental, social and physical improvement in the condition of the people; and in return for this we hope some day to see the claims of the profession more fully recognized and appreciated both by nations and individuals than they are at present. As a sign of the times, and as an earnest of the good things in store for the profession, we may mention the munificent gift of \$500,000 to the College of Physicians and Surgeons of New York by W. H. Vanderbilt, Esq.

In the elucidation of questions in etiology and pathology, great strides have been made. Close upon the heels of the discovery by Koch of the tubercle bacillus, comes the announcement of the comma bacillus by the same observer as the cause of cholera, and although there are those who are not prepared to accept all Koch says about these bacilli, he has not as yet been shown to be wrong in his conclusions. Other commissions have been appointed and we shall look forward to their reports with considerable interest. Pasteur's vaccination experiments, too, in connection with hydrophobia, have been put to the test with the most gratifying results, and from these small beginnings who shall say what grand results may be anticipated?

In medicine and therapeutics much valuable work has been accomplished. The use of convallaria maialis in heart disease has been more fully tested, and while the administration of the tincture in five minim doses has been attended with beneficial results in many cases, yet it requires, according to the experience of Dr. Herschell, care in the selection of cases. In one case in which he exhibited it in cardiac weakness and irregularity, the pulse became almost imperceptible, and there was great oppression, whereas digitalis caused rapid improvement in the patient's condition. Intra-peritoneal injections of albuminate of iron in cases of obstinate chronic anæmia have been recommended by Vachetta. He made numerous experiments on animals and never observed the least peritonitis as a result of the operation, and he regards it as safer than Ponfick's intra-peritoneal injection of blood. He recommends one to two grammes (15 to 30 grs.) of the albuminate of the Ammonio-citrate of iron dissolved in warm distilled water and injected through the abdominal wall near the umbilicus. Dr. B. W. Richardson (*Med.*



*Times and Gazette*) also advises *intra peritoneal* and intra-venous injections of warm saline solutions in the second stage of cholera. Kairine, so highly spoken of as an antipyretic, has on further trial failed to confirm the high estimate formed. Besides, it is expensive, disagreeable to the taste, and transitory in its action. The use of corrosive sublimate in diphtheria has been attended with very good results. It may be administered in doses of  $\frac{1}{2}$  to  $\frac{1}{4}$  of a grain every two hours to a child ten years of age. For topical application it may be made of the usual strength for dressing wounds. Among other uses to which corrosive sublimate has been applied during the year not the least is its application in the treatment of ringworm. Its efficacy is much enhanced by dissolving it in tincture of myrrh, in the strength of four grains to the ounce. The part is painted with the solution twice a day. In the treatment of infectious diseases, and especially typhoid, carbolic acid has been still further experimented with, the results being on the whole satisfactory. It is claimed by those who have tried it that the tongue remains moist, the diarrhoea is lessened, action of the skin is promoted, and the appetite early restored under its use. Dr. Wilks, of Guy's Hospital (*Med. Times and Gazette*) claims to have had very satisfactory results in the treatment of cases of diabetes mellitus with nux vomica and the mineral acids. The patient gained in weight, digestion was improved and the remedies seemed to have a specific action upon the glyco-genic function. Dr. Peyer, of Nottingham, Eng., (*Lancet*), utters a caution to medical men concerning the danger of using iodide of potassium internally and calomel externally, owing to the liability of the latter being formed into the iodide of mercury, and produce destructive action in the part. He gives his own experience in one case and refers to other published cases in support of his contention. The use of paraldehyde in the treatment of *delirium tremens* has again been brought forward by Prof. Gugl. He claims that it proves a prompt hypnotic, and in no case were there any unpleasant symptoms. The dose is from three to six or eight grammes. Dr. Galicer, of Versailles (*Bull de Therap.*), recommends the use of strychnine hypodermically in cases of paralysis. He maintains that used in this way it stimulates the muscles, producing a local as well as a general effect; in other words, it acts like elec-

tricity in paralysis. Notwithstanding the great success in the use of bichloride of methylene as an anæsthetic agent in the hands of Spencer Wells, it has not received much attention from the profession generally. This has no doubt arisen from the fact that two or three deaths occurred from its use when first introduced. M. Le Fort, of Paris, has been giving attention to this agent during the past year, and has come to the conclusion that it is superior to chloroform, inasmuch as the stage of excitement is much less marked and there is scarcely ever any vomiting. This is what Spencer Wells, who has used it in hundreds of laparotomies, always claimed for it. The external use of iodoform-collodion in the treatment of erysipelas has been highly extolled by Dr. Burman (*Practitioner*). He claims that it promptly relieves the burning sensation, reduces the swelling, and arrests the progress of the disease. In acute rheumatism the use of ten minims doses of oil of gaultheria is highly recommended by those who have given it a fair trial. This is not to be wondered at when it is remembered that this substance was the original source of that excellent remedy salicylic acid. In the treatment of angina pectoris with sodium nitrite further successful cases have been published during the year. It should be given in three to five grain doses, as larger quantities are likely to produce unpleasant symptoms. The value of bromide of sodium in the treatment of epilepsy has been made the subject of investigation by Prof. Germain Sée, the result of which is to increase general confidence in its use. He says the efficacy of the drug rests almost exclusively on the depressing influence it exercises on the reflex action of the spinal cord and medulla, and he would therefore rigidly proscribe all stimulants of every form—such as alcohol, tea, coffee, etc. Further use of nitro-glycerine in this affection also shows its value in certain cases in arresting the frequency and violence of the fits. The dose is from one to two drops of a one per cent. solution three or four times a day. As a means of distinguishing between simple ectasis or dilatation of the stomach, and that due to stricture of the pylorus from carcinoma, the fact first pointed out by VanderVelden, and recently investigated by Dr. Kredel, of Giessen, viz., that free hydrochloric acid is absent in the ejecta in cases of carcinoma, is, if true, a most significant and valuable



aid in diagnosis. The results of Dr. Kredel's researches are not only most assuring, but they also afford a hint for the medicinal treatment of these unfortunate cases.

In the domain of general and operative surgery there are many interesting facts to record during the year. A valuable point in intestinal surgery has been given to the profession by Dr. Rand in the *LANCET*, viz., a means of identifying the upper and lower ends of any given piece of small intestine. The mesentery is the guide. Holding the bowel in its true direction, and passing the hand on the right side back to the spinal attachment of the mesentery, it will be on the right side of the spine; but should the apparent upper end be in reality the lower, or, in other words, be held in the wrong direction, the hand passed to the right of it will pass to the left of the spine, and *vice versa*. Mr. Lawson Tait, in the (*Brit. Med. Journal*), gives his method for the radical cure of umbilical hernia by abdominal section, and considers it applicable to other forms of hernia. He opens the sac, frees all adhesions, cuts off omentum that may be in the way, pares the edges of the ring, and stitches up the wound with a continuous silk thread which he leaves permanently. The results have been most satisfactory. The subject of rectal etherization was brought prominently before the profession during the early part of the year, but though taken up with alacrity at first, seems already to have been almost entirely lost sight of. This is to be regretted, as there are no doubt cases in which this method of producing anæsthesia is valuable—such as operations upon the mouth, throat, and palate. We gave in our columns at the time full instructions as to its mode of administration. An improvement upon the ordinary operation for cancer of the rectum has been proposed by Mr. Pollosson. It consists in first making an artificial anus at the sigmoid flexure, and subsequently removing the cancer of the rectum. His idea is, that by this method the rectum is rendered passive and inert before extirpation, and many dangers are thereby avoided. The removal of a cancer of the anus and rectum was successfully performed in the Toronto General Hospital by Prof. Fulton, of Trinity Medical College. The entire anus and three inches and a half of the rectum were removed. The subject of so-called "catheter fever," was brought under the notice of the profession by

a paper read before the London Medical Society, by Sir Andrew Clarke. By catheter fever is meant a severe and sometimes fatal form of fever following the use of the catheter in apparently healthy persons, in whom no lesions to account for death can be found post mortem. As a preventive he advises the use of opiates or anæsthetics, in cases where trouble of this kind may be expected, or has previously occurred. The general opinion of surgeons on this subject, however, is that what Sir Andrew Clarke alluded to was not new, but only one of the forms of urinary fever which follows the use of the catheter. The surgical treatment of large bronchocèles, has been discussed from various points of view. Some recommend their removal by the knife, tying all large vessels entering the tumor before division, so as to prevent loss of blood. Others have successfully treated them by the seton. Another method consists in cutting down upon the isthmus and applying a ligature at its juncture with the lateral lobe on each side and removing the isthmus. In a case operated upon in this way, by Mr. Sidney Jones, great relief from dyspnoea followed. The application of an elastic ligature around the base of the growth has also been quite recently recommended. The treatment of senile gangrene was the subject of discussion before the Royal Chirurgical Society, London. Mr. Jonathan Hutchinson read a paper recommending amputation high up in all cases of senile gangrene, viz.: in the lower third of the thigh and the middle of the arm. In the discussion that followed Mr. Savory said that if the causes were chiefly local, amputation might be successful, but if constitutional it would not, and in such cases he would prefer to leave it to nature. A little later on a very important paper was read before the above named society by Mr. F. Treves, on the direct treatment of spinal caries by operation. In cases of commencing psoas abscess, he cuts down along the outer border of the erector spinæ, opposite the last dorsal and first lumbar vertebræ—the most common site of abscess, gives exit to the pus and removes any sequestra of bone which may be found. In one instance he evacuated 40 ounces of pus and removed a large sequestrum from the body of the first lumbar vertebra. The improvement in the patient's condition was immediate. Several interesting and important cases of suturing the intestines have been reported,

besides experiments on the lower animals, to determine the best method of treatment. The results of treatment in these cases have been such as to lead us to adopt active surgical interference in all cases of traumatic lesion of the bowels. A modification of the Lembert interrupted suture is the one most strongly recommended. The late Prof. Gross, in a paper republished in our columns, very properly, we think, recommends the interrupted silk ligature in preference to catgut. Dr. McDonald, of Edinburgh, reports a case in the March number of this journal, in which he removed several inches of the small intestine, in the course of an abdominal section for extra-uterine pregnancy. The patient made a good recovery. A very interesting case of gastrostomy is reported by Prof. Loreta (*Lancet*), for stenosis of the cardiac orifice. After making an opening into the stomach, the cardiac orifice was dilated by means of a suitable instrument, and the patient made an excellent recovery. Resection of the lung in acute pulmonary gangrene has been successfully performed by Dr. Fenger, of Chicago. In this case an incision was made parallel to the clavicle, the ribs excised sufficiently to permit of the operation, and an opening made through the lung tissue into the cavity with the thermo-cautery. Portions of the putrefied lung tissue were discharged through the opening, and the patient made a good recovery. In the matter of osteotomy for genu-valgum, Dr. McEwen's supra-condyloid operation has come to be regarded as the most successful in its results, and at the International Medical Congress this fact was publicly acknowledged.

Nerve suturing has been again still further put to the test. A case is reported in the *Brit. Med. Journal*, Nov. 29th, in which Prof. Von Bergmann removed two inches of the shaft of the humerus in order to be able to unite the nerves which had been widely separated as the result of a wound by a circular saw. Successful cases of extirpation of the spleen have been chronicled from time to time during the year. A successful case was recently reported by Von Hecker, assistant to Billroth. So far there have been 36 cases of extirpation of the spleen. Of these 24 were for leukæmia, of which only one recovered.

The antiseptic treatment of wounds, *a la* Lister, is still being carried out by his disciples in all parts of the world, but the antiseptic agents used are

being changed from time to time. Corrosive sublimate dissolved in blood-serum (1 part to 100) is the agent recommended by Mr. Lister at a recent meeting of the London Medical Society. The introduction of the new local anæsthetic muriate of cocaine in ophthalmic and general surgery will within certain limits undoubtedly prove of great value to the profession. It is easily applied and its anæsthetic effects are sufficiently complete to render it useful in operations where a transient effect is all that is necessary.

In the matter of obstetrics and gynecology there has been much material progress. In the early part of the year the subject of puerperal fever occupied the attention of some of the most prominent gynecologists, and much was said and written regarding the use of prophylactics, the practical outcome of which was to impress upon the professional mind the oft-repeated maxim that cleanliness is the greatest of all prophylactics. As is usual in human affairs there was a tendency manifested to go to extremes in regard to the measures to be used to prevent the occurrence of puerperal fever, septicæmia, etc. Dr. Thomas, who read a paper before the N.Y. Academy of Medicine, strongly advocating the most active interference in the puerperal state, afterwards so far modified his former expressions of opinion as to bring them into harmony with those who advocated less active measures. The combined method of turning in placenta prævia has again been brought more fully under the notice of the profession by Dr. Behm, of Berlin. The advantages claimed for this method are the avoidance of sepsis and the limitation of the loss of blood, from atonic post-partum hemorrhage. His plan is to leave the case entirely to nature after getting the breech down to the os—"haste" in performing combined turning, "delay" in extraction. The application of the forceps to the breech in certain cases has also been advocated by Truzzi (*Gaz. Med. Ital.*) contrary to the teaching of former times. He regards their use as preferable to traction on the groin by the finger, fillet or blunt hook. Porro's operation has been the subject of earnest discussion, by some of the leading gynecologists during the year. Dr. Godson read a very interesting and valuable paper on this subject before the British Medical Association in Belfast, giving ample data upon the status of the operation from a statistical point of view. In 131

cases the total mortality amounted to a fraction over 55 per cent. from which he is warranted in drawing the inference that the operation is one from which most satisfactory results may be obtained in properly selected and managed cases. Too many such cases are put off until it is too late to expect a successful issue. In the vomiting of pregnancy, iridin has been recently most enthusiastically praised as a remedy. M. De Musy (*Progrès Medical*) stated at the Société de Therap. that the Edinburgh physicians has used it extensively. Dr. Berry Hart had used it in ten cases without a single failure. The dose is three grains in pill form with conserve of roses every night, followed by a saline purgative in the morning. Hydrastis Canadensis has been used with great success by numerous observers both at home and abroad, in the treatment of uterine hemorrhage, and the results have been on the whole most satisfactory. It appears to produce contraction of the arterioles and lessen congestion, its action being somewhat similar, but more reliable than ergot. The dose is ten to twenty minims of the fluid extract. In the treatment of uterine displacements, Dr. Bell (*Lancet*) claims to have had excellent results from the use of medicated tampons. The substances he uses are alum, carbolic acid and glycerine, which he says support, deplete and invigorate the uterus and vagina. Mr. Lawson Tait reports (*Brit. Med. Four.*) five cases of laparotomy for extra-uterine pregnancy, with four recoveries. The diagnosis in these cases is perhaps the most difficult part, but Mr. Tait never hesitates to open the abdomen. If a patient has been eight weeks or more without a period, and a pelvic mass can be felt on one side of the uterus and fixing it, and if sudden symptoms of pelvic trouble and hemorrhage come on, rupture may be suspected and abdominal section should be performed at once. Mr. Tait in his address on abdominal surgery at the meeting of the Canada Medical Association, gave us some idea of the reason of his remarkable success, viz., entire restriction to his chosen field, minute attention to every detail, together with great attention to cleanliness in every part of his work.

The association meetings during the year were more than usually well attended, and an increasing interest was manifested in all the proceedings. The various Provincial Associations in Ontario,

New Brunswick and Nova Scotia, were well attended, and much valuable work was accomplished. The New Brunswick Medical Association decided to enter upon the experiment of publishing a quarterly medical journal, but we have not yet seen the first number. The Canada Medical Association met in Montreal in August under the presidency of Dr. Sullivan of Kingston, and under the most favorable circumstances. The interest of the meeting was greatly enhanced by the presence and active co-operation of members of the British Association for the advancement of science. Many instructive and valuable papers were read and discussed, not the least of which was the admirable address on abdominal surgery by Mr. Lawson Tait. The profession of Montreal in their hospitality exceeded all previous efforts, and both the social and intellectual proceedings were highly spoken of by all who participated. Dr. Osler was elected President for the ensuing year, and Winnipeg was chosen as the next place of meeting on the third Tuesday in August, '85. The American Medical Association met in Washington in May, under the presidency of Dr. Flint, Sr. Upwards of 1200 members were present and the meeting was most successful in every respect. The code, contrary to what was expected in some quarters, occasioned no difficulty. The work of the session was well sustained. The Journal of the Association came in for a share of criticism, but it was decided to give it another year's trial. Dr. Campbell, of Georgia, was elected president, and New Orleans chosen as the next place of meeting on the last Tuesday of April, 1885. The meeting of the British Medical Association was held in Belfast in July, Dr. Cuming, president, in the chair. A number of distinguished foreigners were present, besides delegates from the United States and Canada. Able addresses were delivered on medicine, surgery and obstetrics, and the work of the sessions was earnest and active. The social aspect was of the most brilliant and hospitable character. The eighth session of the International Medical Congress opened in Copenhagen on the 10th of August, under most favorable auspices. The attendance comprised about 1600 medical men of all nationalities. The meeting both intellectually and socially was a great success. The next meeting is to take place in Washington, in 1887, under the presidency of Dr. Flint, Sr.

During the past year the following new books and new editions of old ones have been issued from the press:—*Syphilis in New-born Children and Infants*, Diday; *Materia Medica and Therapeutics*, Bartholow; *Student's Manual of Chemistry*, Witthaus; *Operations of Surgery*, Bell; *Pathology and Treatment of Venereal Diseases*, Bumstead; *Roller Bandage*, Hopkins; *Medical and Surgical Uses of Electricity*, Beard; *Manual of Diseases of Nose and Throat*, Kitchen; *Oral Surgery*, Garretson; *Hand-book of Chemistry*, Greville; *Hand-book of Skin Diseases*, Kippax; *Influence of the mind upon the body*, Tuke; *History of Tuberculosis*, Spina; *Manual of Practical Hygiene*, Chaumont; *Bright's Disease of Kidneys*, Millard; *Practical Pathology*, Woodhead; *International Encyclopædia of Medicine*, vol. iv., Ashhurst; *Dictionary of Medicine*, Quain; *Treatise on Pharmacy*, Parrish; *Therapeutic Hand-book of U. S. Pharmacopœia*, Edes; *Manual of Obstetrics*, King; *Treatise on Surgical Diagnosis*, Ranney; *Epitome of Skin Disease*, Fox; *Guide to American Students in Europe*, Hun; *Hand-book of Forensic Medicine and Medical Police*, Husband; *"Shakespeare as a Physician,"* Chesney; *Elements of Pharmacy, Materia Medica, and Therapeutics*, Whitla; *Opera Minora*, Seguin; *Elementary Principles of Electro-Therapeutics*, Haynes; *Medical Ethics*, Hamilton; *Elements of Surgical Pathology*, Pepper; *Clinical Lectures on Mental Diseases*, Clouston; *Brain Exhaustion*, Cornell; *Deutch's Medical German*; *Diseases of Rectum and Anus*, Kelsey; *Gonorrhœa*, Milton; *Obstetrics*, Verrier; *Diseases of Heart*, Paul; *Eczema*, Buckley; *Second Annual Report of Ontario Board of Health*; *Clinical Chemistry*, Ralfe; *Dissector's Manual*, Clarke; *American System of Practical Medicine*, Pepper; *Electro-Therapeutics*, Amidon; *Diseases of Throat and Nose*, McKenzie; *Diseases in Children*, Smith; *Manual of Obstetrics*, Partridge; *Auscultation, Percussion and Urinalysis*, Leonard; *Visions of Fancy*, Baskett; *Hooper's Physician's Vade Mecum*; *Materia Medica and Therapeutics*, Bruce; *Principles and Practice of Medicine*, Davis; *Practical Medicine*, Loomis; *Malaria and Malarial Diseases*, Steinberg; *Diseases of Women and Uterine Therapeutics*, Jones; *Medical Rhymes*, Erichsen; *Lock-jaw of Infants*, Hartigan; *Fractures and Dislocations*, Hamilton; *Science and Art of Surgery*, vol. i., Erichsen; *Pathology and Morbid Anatomy*, Greene, etc.

Among those of our confrères who have passed away during the year, may be mentioned,—S. F. Whitman, Bridgetown, N. S.; H. Bennett, Priceville; J. Reddy, Montreal; J. Thomson, Chatham, N. B.; J. R. Tabor, Whitevale; A. C. Savage, Chicago; J. R. Smith, Harrowsmith; C. H. Lavell, Kingston; R. Black, Wickham, N. B.; E. Clay, Halifax, N. S.; J. F. Coad, East Zorra; C. Deguise, Quebec; Wm. James, Burgessville; P. N. Leclair, North Lancaster; S. W. Cooke, Paris; —. Kittson, St. Paul, Minn.; J. J. Dickinson, Cornwall; R. Stephen, Digby, N.S.; J. E. Landry, Quebec; H. Maudesley, Moorefield; H. C. Fixott, Arichat, N. S.; E. Morton, Queensville; G. A. Kent, Wallace, N. S.; J. A. Aikman, Ingersoll; J. S. Diamond, Toronto; G. Willcock, Toronto; E. Jennings, Halifax; G. H. Nelson, Santa Barbara, Cal.; Jas. McCammon, Kingston; A. B. Craig, Montreal, etc. Among those in foreign lands may be mentioned,—Prof. Balfour, Alex. Wood and Allan Thomson, Edinburgh; C. H. Hawkins, London, Eng.; Prof. Jäger, Vienna; —. Radcliffe, Engiand; Prof. Cohnheim, Leipsic; Profs. Gross and Rogers, Philadelphia; Prof. Parker, New York; Dr. Dugas, Georgia; Dr. L. P. Yandell, Louisville, etc.

The outbreak of cholera during the past year in the south of France and its extension to other points in Europe, and recently to Paris, strikes the note of alarm, and bids us prepare to ward off the impending blow. Our sanitarians in Canada and the United States are united in making representations to their respective governments, with the view of dealing promptly with the adversary should it unfortunately reach our shores. Various outbreaks of smallpox and diphtheria have taken place at different times and in different localities, but upon the whole the health of the community has been no worse than in former years. We conclude by wishing our many readers a happy new year, great and increasing prosperity, and long lives of usefulness.

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JAMES McCAMMON, M.D., M.R.C.S., ENG.

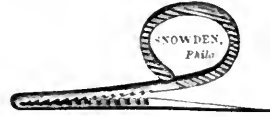
Dr. McCammon, whose death recently took place, was born in Kingston, Ont., in 1833, and there received his primary education. On reaching manhood he first devoted his attention to school teaching, after qualifying himself for the duty by

attendance at the Normal School, Toronto. He followed this occupation with remarkable success for several years, after which he turned his attention to the study of medicine, and graduated with honors in Queen's College in 1863. He subsequently practised for several years in Newburgh, Ont., where he acquired a lucrative practice. In 1871 he visited the European hospitals determined to acquire experience and obtain a wider knowledge of surgery and physic. He there obtained the diploma of the Royal College of Surgeons, Eng., and on his return settled in Kingston. He was for several years a member of the Ontario Medical Council, and was recently appointed to the chair of clinical surgery in the Kingston Medical School, which position he filled with marked ability and favor. He was also a member of the Council of Queen's University. He was elected mayor of his native city in January last, and was most assiduous, as indeed in everything else, in the performance of his civic duties. In the death of Dr. McCammon the profession of Canada has lost one of its most active and intelligent members and the city of Kingston its chief magistrate and one of its most valuable citizens. The sick poor of the city have lost a sincere and self-sacrificing friend, and his wife and family a devoted father and husband.

**THE LYNAM CASE.**—About two years ago Mrs. Lynam was considered insane, and was sent to the Longue Point Asylum by the certificate of the visiting physician. Recently a Mr. Perry, who interested himself in her behalf, became convinced that she was sane, and applied to Judge Jette to have her produced in court, in order to test the question of her sanity or insanity. Experts, or so-called experts were called to testify, and as is usual under such circumstances, some of them declared her insane, while as many of equal authority pronounced her sane. The judge was, of course, bewildered, and accordingly put Mrs. Lynam in the witness box, and is said to have given her a most severe examination, which she bore with great calmness and fortitude. He finally decided to appoint Dr. Vallee of the Beauport Asylum, to examine her, and suggested that the Quebec Government should appoint two others to act in conjunction with him. The government have been

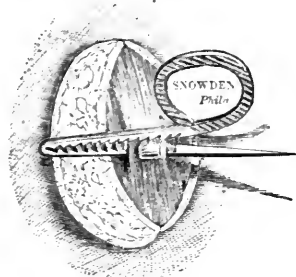
dilatory in the matter, but Dr. Vallee has visited Mrs. Lynam, and has filed his report in the superior court, declaring her in his opinion, to be sane.

**ARTERY-COMPRESSOR.**—A convenient and effective appliance has been devised by Dr. Levis for the rapid arrest of hemorrhage in large open wounds. It is exceeding simple and inexpensive.



Numbers of the compressors can be quickly applied during an operation, and the surgeon may leisurely ligate the vessels if after their removal, the ligature should be required. In many operations attended for the time by great hemorrhage from numerous small vessels, the temporary stasis produced by the compressors will be sufficient to prevent further flow.

By this device the operator can proceed to the end of an operation without stopping to apply ligatures.



The instrument and its application are so illustrated in the cuts that description is unnecessary. The compressors are made by Snowden, 7 South Eleventh Street, Philadelphia, and the price is only 25 cents each.

**SUBCUTANEOUS INJECTION OF MORPHIA IN CHOLERA.**—Dr. Brown, of Clayton, Ont., has called our attention to the following which was published in the LANCET several years ago, and which we now re-publish: "Dr. Patterson, of Constantinople (*Braithwaite*), reports that in the late epidemic of cholera in that city, finding all other treatment unsatisfactory, he determined to try the subcutaneous injection of morphia. In the first case a quarter of a grain of the acetate caused relief to the cramps and vomiting in a quarter of

an hour, and the skin became gradually warm and moist, and the pulse returned. In ordinary cases he found one or two injections sufficed, in a few three were given, and only once four. He does not maintain that the treatment is a specific against cholera, but that its action is more speedy, certain and effectual than any other tried by him. Out of thirty-two cases in which the treatment had a fair chance, there were only ten deaths."

**MORE ADVERTISING IN THE LOCAL PRESS.**—Inasmuch as the LANCET is again on the war-path, the following "most extraordinary case" under the care of Dr. Hamilton, of Port Hope, Ont., may be alluded to. The item, which appears to have been written, or at all events the facts supplied by a medical man, appeared in the *Port Hope Guide*, Dec. 5th. A young man was wounded in the orbit by a piece of wood. The doctor, after "probing the wound, discovered a foreign body," and advised an operation. He gave chloroform, "enlarged the wound," and on laying hold of the "foreign body" with a "strong forceps," removed it, &c. We leave our readers to judge of the paternity of the offspring.

**INTERNATIONAL MEDICAL CONGRESS.**—The Committee on Organization of the 7th International Medical Congress, to be held in Washington in 1887, met recently and the following officers were elected: *President*, Dr. Austin Flint, Sr., New York. *Vice-Presidents*, Dr. Alfred Stille, Philadelphia; Dr. Henry I. Bowditch, Boston; Dr. R. P. Howard, Montreal. *Secretary General*, Dr. J. S. Billings, U. S. Army; *Treasurer*, Dr. J. M. Browne, U. S. Navy. *Members of the Executive Committee*, Dr. I. Minis Hays, Philadelphia; Dr. Jacobi, New York; Dr. Johnston, Baltimore; Dr. Busey, Washington.

**REMOVAL OF LARGE CALCULI.**—Dr. Hingston, of Montreal, removed from the bladder a calculus weighing five ounces and five drachms, and measuring upwards of nine inches in its greatest circumference. The lateral method was adopted and the patient, a youth of 21 years, made a rapid recovery. Dr. Burns, of the Toronto General Hospital, also removed a calculus from the bladder a few months ago by the supra-pubic method, weighing three and a half ounces, and measuring two and three quarter inches in its greatest diameter. The

patient, aged 21 years, unfortunately died within 24 hours.

**REMOVAL OF A TUMOR OF THE BRAIN.**—Mr. Godlee recently removed a tumor from the substance of the brain at the hospital for epilepsy and paralysis, London, Eng. The case was under the care of Dr. Hughes Bennett, who diagnosed the existence of a tumor in the upper part of the fissure of Rolando, and requested the surgeon to trephine over the suspected region. A mass of glioma the size of a walnut was successfully removed and the patient had progressed favorably up to the time of writing.

**SANITARY CONGRESS.**—Dr. C. W. Covernton, Chairman of the Ontario Board of Health, has been requested by the Dominion Government to represent Canada at the Sanitary Congress held in Washington. Dr. Canniff, medical health officer for Toronto, has also been sent as a delegate. The object of the meeting is to recommend to the governments of the United States and Canada the adoption of measures to prevent the invasion and spread of cholera, which is confidently expected to visit our shores next summer.

**REMOVAL OF A CYSTIC KIDNEY.**—Dr. McLean, Prof. of Surgery, Ann Arbor, Mich., (*Phys. & Surg.*) formerly of Kingston, Ont., removed the left kidney which was in a state of cystic degeneration, both ovaries and a portion of the greater omentum, on the 26th of October last, from a woman supposed to be pregnant (2nd or 3rd month). At last accounts, seventeen days after the operation, the patient was doing well.

**EPIDEMIC OF SMALL-POX.**—An epidemic of this loathsome disease has broken out in the county of Hastings. In the village of Stoco, scarcely a family has escaped the scourge. The secretary of the Ontario Board of Health, Dr. Bryce, has made a tour of inspection of the district, and is doing all in his power to prevent the spread of the disease.

**VACANCIES IN U. S. ARMY AND [NAVY.**—The *Medical Record* of New York states that for several years there have been a number of vacancies in the United States army and navy medical department. There are not enough applicants to fill the situations. This ought not to be the case, inas-

much as the position is a very desirable one for a young man, and the salary is very good.

**ANOTHER LOCAL ANÆSTHETIC.**—Our attention has been drawn by Dr. Ryerson of this city to the anæsthetic powers of Rhigolene, a drug introduced to the profession some time since by Dr. H. J. Begelow, of Boston. Rhigolene is a naphtha obtained by re-distillation of petroleum. It is not a definite compound but is the most volatile liquid known and one which produces the greatest cold on evaporation. It is highly inflammable. Used in the form of a spray it freezes rapidly and *deeply*. Its effects are somewhat evanescent, but can be maintained by frequent sprayings. It seems likely that Rhigolene may play a prominent rôle in general surgery, inasmuch as the hydrochlorate of cocaine has been found to be a comparative failure when applied to the unbroken skin, and when injected hypodermically has produced unpleasant constitutional symptoms, with imperfect local results.

**LIGATURE OF THE CAROTID AND JUGULAR VEIN.**—Dr. Deakin (*Lancet*, Nov. 15th), has recently applied a ligature to the right common carotid artery, and two to the jugular vein, in the removal of an epithelial tumor of the neck. Although a cure could not be looked for in the case, the result of the operation was satisfactory.

**AMYL NITRITE IN ASTHMA.**—Dr. W. B. Richardson, of London (*Asclepiad*, July, 1884) gives the following formula for its administration: R. Amyl Nitrite, M. xxxv., Alcohol, ℥v., pure glycerine to ℥iss,—M. One fluid drachm in a wineglassful of warm water.

**SUCCESSFUL OVARIOTOMY.**—Mr Knowsley Thornton has lost but three of his last one hundred ovariectomies. He is a follower of Lister. Of the three patients that died one had malignant disease and the others died of hemorrhage.

**THE death of Dr. Henry Martin, of Boston, who has been for years identified with vaccination, is announced in our exchanges. His son will continue the business.**

**GLEET.**—*Pinus canadensis* is a specific in gleet. Its action is prompt and permanent.

## Books and Pamphlets.

**A PRACTICAL TREATISE ON FRACTURES AND DISLOCATIONS**, by Frank Hastings Hamilton, M.D., LL.D., late Prof. of Surgery in Bellevue Medical College and Surgeon to Bellevue Hospital, New York; St. Elizabeth Hospital, etc.; Author of a Treatise on Military Surgery and Hygiene, a Treatise on the Principles and Practice of Surgery, etc. 7th American edition, revised and improved. Illustrated with three hundred and seventy-nine wood cuts. Philadelphia: H. C. Lea's Son & Co. Toronto: Williamson & Co.

This most excellent and classic work of Prof. Hamilton has now been before the profession for a quarter of a century, and is well known to surgeons both at home and abroad. The present edition has been carefully revised and re-written, and new matter has been introduced, which adds to its value as a work of reference. The work now comprises about 1,000 pages octavo, and is noted alike for its originality and completeness. The author has taken nothing for granted, and commends no procedure for which he does not find a warrant in the results of his own experience. From the beginning of his studies, he declares, he has found one of his most difficult labors in attempting to eliminate from surgery the numerous "false facts" or unreliable statements derived from observations made on the cadaver or on cabinet specimens whose history is unknown. We unhesitatingly recommend the work to our readers.

**THE SCIENCE AND ART OF SURGERY.**—By John Eric Erichsen, F.R.S., LL.D., F.R.C.S.; Emeritus Prof. of Surgery in University College, etc. Eighth Edition. Revised and Edited by Marcus Beck, M.D., Land, F.R.C.S. Prof. of Clinical Surgery in University College, London. With 984 Engravings on Wood. Volume I. Large 8vo. Pp. 1124. Philadelphia: Henry C. Lea's Sons & Co. Price, \$5.50.

Each of the various editions of this magnificent work has been noticed by us from time to time. It is only necessary for us now to inform our readers in regard to the present edition, which the author has thoroughly revised in order to bring it abreast of the knowledge of modern surgery. Erichsen's surgery since its first publication, more than thirty years ago, has held a position second to no other work upon surgery as a text book or a work for reference both in England and in this



country. When it consisted of but one volume, its convenient size and completeness of detail commended it, in our estimation, as one of the most valuable texts books for students. Yet although enlarged and made into two volumes, it is so free from prolixity and tediousness that we have no hesitation in recommending it to the attention of students as well as the general practitioner.

**THE NATIONAL DISPENSATORY**, containing the Natural History, Chemistry, Pharmacy; Action and Uses of Medicines. By Alfred Stillé, M.D., LL.D., and John M. Maisch, Phar. D. Third Edition thoroughly revised, with numerous additions, with three hundred and eleven illustrations. Philadelphia: Henry C. Lea's Son & Co., Toronto: Williamson & Co.

This valuable work is already so well known to the profession in Canada and the United States as to require only a brief notice at our hands. Complete information will be found in regard to all remedies, both old and new. Even in the matter of the new local anæsthetic it contains the fullest information. The work is almost a necessity to every practitioner of medicine as a book of reference.

**DISEASES OF THE EYE**, by Henry R. Swanzy. New York: D. Appleton & Co. Toronto: Hart & Co.

This book, which is about the same size as Dixon on the eye, is intended for the use of students attending an ophthalmic hospital, but will also be found very useful as a convenient work of reference for practitioners. The work is largely a compilation from standard works. The author rarely putting forward his own opinion or practice very prominently. The work is well and appropriately illustrated, and the text well written. A very interesting chapter treats of the motions of the pupil in health and disease.

**MANUAL OF CHEMISTRY** by W. Simon. Philadelphia: Henry C. Lea's Son & Co. Toronto: Hart & Co.

This may be considered, in some respects at least, as a companion work to the foregoing. It is intended as a guide to a course of lectures on general chemistry, but will be found especially useful to pharmaceutical and medical students. The work treats of organic and inorganic chemistry, qualitative analysis, physiological chemistry, etc.

The work is well 'printed on good' paper and clear legible type, and is well adapted to the use of the general student of chemistry.

**PHYSIOLOGICAL AND PATHOLOGICAL CHEMISTRY**, by T. Cranstoun Charles. Philadelphia: Henry C. Lea's Son & Co. Toronto: Willing & Co.

A knowledge of this branch of medicine is of great importance in the study of the science and art of medicine. Physiological chemistry promises much in the treatment of disease. The work before us gives an excellent outline of the most important branches of physiological chemistry, and in order to render the work more complete the author has given brief descriptions of such bodies as sugars, fats and certain salts. We commend the work to the attention of the student of chemistry.

**THE PHYSICIAN'S VISITING LIST** (Lindsay & Blackiston) FOR 1885. Thirty-fourth year of its publication. Philadelphia: P. Blackiston, Son & Co.

This popular List continues to maintain its former reputation. It was the pioneer in this line of publications, and fulfils every requirement of a daily companion. Every practising physician should have a visiting list; it will save him ten times its cost in the year.

**THE MEDICAL RECORD VISITING LIST FOR 1885**. New York: W. Wood & Co.

We have received a sample copy of this valuable and popular visiting list. In its preparation nothing has been omitted which is necessary in a pocket record. It is most concise, compact, and handsomely finished work, and will be found a most useful companion.

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### **Births, Marriages and Deaths.**

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On the 10th of December, P. J. Strathy, M.D., M.R.C.S., Eng., to Fannie, youngest daughter of the late J. Alley, Esq., Toronto.

In Kingston, on the 29th of November, James McCammon, M.D., Mayor of Kingston, aged 51 years.

In Montreal, on the 12th of November, A. B. Craig, M.D., aged 60 years.

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*\*\* The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

# THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

VOL. XVII.

TORONTO, FEB., 1885.

No. 6.

## Original Communications.

### INTERNAL OBSTRUCTION OF THE BOWELS.

BY A. B. ATHERTON, M.D., L.R.C.P. & S. ED., TORONTO.

(Formerly of Fredericton, N.B.)

CASE I.—August 12th, 1883. G. L., male, æt. 25. Always healthy. Never laid up by illness in his life. Ate some green peas at yesterday noon, and a quantity of ham in the evening. Was seized with violent pain in the abdomen at 1 a.m. A free movement of the bowels took place at 3 a.m. Pain continued and vomiting then also began. 30 drops of laudanum were administered by a friend, but with little relief. Was visited by me at 8 a.m., when I gave  $\frac{1}{3}$  gr. of morphine hypodermically. This kept the patient pretty easy till noon, when half an ounce of castor oil with 30 drops of laudanum were taken. At 5 p.m. the pain became so severe again that I repeated the morphine as before.

Aug. 13, 8.30 a.m.—Pain returned early this morning. Vomiting is frequent and copious, and no motion of the bowels has occurred since yesterday morning; morphine repeated, also half a drachm of spirits of turpentine in warm soap and water administered in the form of an enema; to be followed in half an hour, if no action of the bowels, by a quart of warm water. Turpentine stupes externally.

8 p.m.—Free vomiting during the day, though only 2 or 3 cups of tea have been swallowed. Vomited matters are of a sour taste and smell, and also very bitter. No flatus has passed per anum since the attack began; neither has any of the enemata come away. Pulse, 104; temp. in mouth, 99.8°. Little or no abdominal distension. Pain and tenderness are greatest in the epigastric region. Morphine repeated in the arm. Also

ordered a pill of  $\frac{1}{3}$  gr. morphine and  $\frac{1}{2}$  gr. of ext. belladonna, to be given pro re nata. To have only iced milk and lime water in small quantities.

Aug. 14, 10 a.m.—Rested pretty fairly till 3 a.m., when the pain and vomiting returned. Has taken 6 of the pills since that hour, but probably several of them were vomited. The amount of greenish sour fluid ejected is still large, though little ingesta is taken. The urine has been very scanty from the first. Pulse, 96; temp. 99.2°. Face looks somewhat pinched. Hypodermic injection of morphine repeated. To suck bits of ice and swallow little else.

12.30 p.m.—Comfortable since morning, and not much vomiting. About 3 quarts of warm water administered very slowly as an enema through a long tube. No great amount of force was required to inject it, but the patient complained of a good deal of pain at the last, and I then desisted. He then got up and passed about two quarts in gushes. Little or nothing came away in the water. Ordered a suppository containing  $\frac{3}{4}$  gr. of morphine and 1 gr. of ext. of belladonna pro re nata to relieve pain.

8.30 p.m.—Vomiting continues. Used one suppository about half an hour ago. No further motion from the bowels. Abdomen seems to be growing flatter, especially from umbilicus downwards. Pulse, 108; temp. 99.5°.

Aug. 15, 9 a.m.—Rested fairly well without any more opiate. Vomiting not quite so frequent, but the fluid thrown up has an intestinal odor. Had some hiccough during the night. Feels less pain; no improvement in facial expression. Pulse 96, small and compressible; temp. in mouth, 97.5°; in rectum, 99°.

11 a.m.—Dr. Coburn, of Fredericton, saw the patient with me, and agreed in the opinion that there must be some intestinal obstruction. As, however, he had been rather freer from pain and vomiting, and some flatus had passed per anum, for the first time this morning, it was deemed advisable to wait a few hours before operating. Pulse, 120; temp. in mouth, 99.8°; in rectum, 101°. Extremities rather cool.

8 p.m.—Vomiting of intestinal—smelling matter continues. Pulse 128, feeble; temp. as before. Mind has wandered at times during the day.

Operation (by lamplight).—Chloroform, followed by ether. Assisted by Dr. Coburn, and Messrs.

Owens and Sury, my medical students. The anæsthetics were taken badly. The catheter was passed but no urine found. A longitudinal incision was made, commencing to the left of the umbilicus and extending down about four inches. On cutting through the peritoneum, congested small intestine presented itself. On examination two loops were found connected closely together by a very short band of adhesion, which dragged upon one part so as to constrict very considerably the gut. I could scarcely insert the tip of the finger beneath this band and adjoining loops of bowel. A catgut ligature was thrown around the adhesion and tied. There was no room for a second one, and I therefore divided the band with the scissors. No bleeding followed. As only a few inches of the intestine seen was much distended, there was no protrusion; and I readily brought the abdominal wound together with deep silver sutures and superficial catgut ones. Carbolic spray and other antiseptic precautions were used throughout.

10.30 p.m.—The patient has been very restless and pugnacious since coming out of the ether, and it was with difficulty he could be kept in bed. Has swallowed a few teaspoonfuls of iced milk, and has had an ounce of brandy in a cup of warm milk and water by enema. No vomiting since the operation, and flatus has passed several times per anum. Extremities are pretty cold. Pulse 132, very feeble. Hot irons put to feet.  $\frac{1}{4}$  gr. morphine subcutaneously, to help keep the patient quiet.

Aug. 16, 8.30 a.m.—Slept 4 or 5 hours altogether during the night. Took some brandy and milk by the mouth, and had an enema of the same at 3 a.m. No vomiting; no motion of the bowels. Wildly delirious at times. Extremities cold. Little or no pulsation at wrists. He died at 10.30 a.m.

*Autopsy* 11 a.m.—The point at which the ligature was applied was found to be only 4 feet from the pyloric end of the stomach. A considerable thickening of the peritoneal coat ran in a somewhat band-like form around the gut from the ligatured adhesion. Along this line the bowel presented somewhat of a wet leather appearance, but there was no ulceration of the mucous coat at the part, and the calibre of the intestine was not very greatly diminished either here or elsewhere. Stomach and upper 4 feet of bowel dilated; be-

low this the latter was empty and contracted. Two of the mesenteric glands were calcareous.

**CASE II.**—Oct. 19, 1883.—A. J.'s child, æt. 11 months, female. A few weeks ago the child had measles, which was followed by a serious attack of bronchitis. Two or three days since the patient began to suffer from vomiting and diarrhoea, but was not ill enough for a physician to be sent for. At 2.30 a.m. the patient awoke with pain and vomiting, and the passage of a thin, bloody fluid from the bowels. Was visited by me at 5 a.m. I gave at once 6 or 7 drops of tinct. opii in a little warm water as an enema, and ordered her to have 2 drops of the same by the mouth *pro re nata*, also to take only one teaspoonful of barley water every half hour. The distress seemed very great when the patient vomited, and the fluid ejected resembled very much the rice water which she had been drinking during the night.

11 a.m.—Has required one or two doses of the laudanum, and has been much easier. No further vomiting, though there has been a little retching. Two bloody discharges. Continue opiate as before, and two teaspoonfuls of barley water at a time.

8 p.m.—Vomiting has come on again, and the bloody dejections have been more frequent. Pulse, 160; temp. beneath arm, 101°. Rather pale and collapsed-looking. On examination per rectum, no tumor felt, though anus seemed more patulous than usual. No great abdominal distension, and no marked tenderness on palpation. On deep pressure a cylindrical tumor was found lying just to the left of the median line, and extending from the pubes upwards to the side of the umbilicus, being about  $3\frac{1}{2}$  inches in length and  $1\frac{3}{4}$  inches broad. Resonance not quite so good over the swelling, but no marked dulness present. I now wrapped a piece of rag about the base of the nozzle of a Davidson's syringe, so as to form a plug for the anus; and, holding the instrument tightly against the fundament, I injected slowly a pint or more of warm water, while, at the same time I manipulated the tumor through the abdominal walls. During this procedure the swelling appeared to move somewhat towards the right and disappear. I now allowed the water to escape, and examined the abdomen again. No swelling felt above pubes, but as I imagined there was an abnormal fulness and hardness in the right hypo-

chondriac and epigastric regions, I repeated the enema with the head and shoulders lowered. During the administration of the last of the enema, about six ounces of greenish fluid burst from the mouth, and I then allowed the water to escape per anum. No fæcal matter, mucus, nor blood came away with either enema.

10 p.m.—Has rested well since enemata. No vomiting, and no movement of the bowels since visit. No tumor felt. Pulse, 145.

Oct. 20, 9 a.m.—Doing well; pulse, 136. Countenance improved. 9 p.m.—No vomiting since the disappearance of the tumor. Has had two or three greenish motions to-day. No blood.

Oct. 21.—Appears almost well. Takes the breast and vomits nothing.

REMARKS.—That a distended abdomen is not necessarily present in all cases of internal obstruction is quite evident from the first case reported above. The belly was really *retracted* in that instance, which was of course due to the seat of trouble being so close to the stomach, thereby leaving only a few feet of intestine above to be dilated, the portion below becoming empty and contracted as is usual. It would undoubtedly have afforded this patient a much better chance for life if laparotomy had been done earlier; but one is apt to hesitate and delay about resorting to so serious an operation, that the latter is often not undertaken until symptoms of collapse, or general peritonitis, or gangrene supervene, and then the patient succumbs. I intended to have performed the operation on the morning of January 15th. had there not occurred a passage of flatus downwards for the first time, which led me to hope that the obstruction was about to yield. Besides, it will be observed that the abdominal section was made before the end of the 4th day, and as I had previously operated on two cases\* of internal strangulation at the end of the 5th and 6th day respectively—the former of which recovered, and the latter lived till the 7th day after the operation—I thought I could afford to wait a little. But it is quite clear that the *length of time* that has elapsed cannot be relied upon entirely as a guide to the condition of the bowel, and consequent urgency for surgical interference, any more in cases of internal obstruction than in those of strangulated hernia, and one

must evidently be largely governed as to the advisability of immediate operation by the degree of the acuteness as well as the severity of the symptoms attending the attack.

As to the character of the second case reported, I think there can be little room for doubt. The acuteness of the symptoms, the vomiting, the passage of the thin, bloody serous discharges, the presence of the sausage-like tumor, and the speedy and complete relief obtained by the use of the large enemata, all combine to prove the existence of an intussusception. The patulous condition of the anus, I think, is also mentioned by some as likely to be found in such cases. I did not give an anæsthetic before administering the enemata, because I did not suppose there would be much muscular resistance offered to prevent the reduction of the bowel in a subject so young, and in one who was so much prostrated by the disease. The readiness with which that object was attained is sufficient evidence that the assistance of such was not required.

#### THORACO-PLASTIC OPERATION OF ESTLANDER \*

BY J. FULTON, M.D., M.R.C.S., ENG., L.R.C.P., LON.

Prof. of Surgery and Clinical Surgery, in Trinity Medical College, Toronto; Surgery to the Toronto General Hospital; Author of Text-Book of Physiology.

GENTLEMEN,—It is not possible for me, within the time assigned, to discuss satisfactorily the pathology, or even the clinical history of empyema, although the disease is one of the most interesting which the surgeon is called upon to treat. I shall, therefore, confine myself entirely to the treatment of the chronic form of the disease by what is known as Estlander's operation. I also desire to draw the attention of the profession to this operation which, so far as I know, has rarely been performed in America the first reported case being given by Dr. Fenger, of Chicago, in the *Medical News* for Sept. 1882.

The resection of a portion of a rib for the more thorough evacuation of pus, and for the application of remedies to the cavity of the pleura, has long been practiced; but the object which Estlander had in view in his operation, was the obliteration of the suppurating cavity and occlusion of the per-

\* Reported in Boston *Med. and Surg. Journal* of June, 1883.

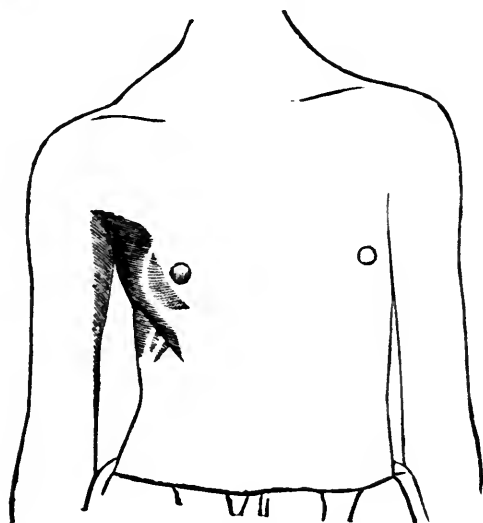
\*Read before the Canada Med. Association, August, 1884.

manent pleural fistulæ which are consecutive to the incision in empyema. I need scarcely say that nearly all intelligent surgeons of the present day treat cases of empyema, especially in the adult, by free incision and drainage, together with thorough washing out and disinfection of the cavity. The results of this method of treatment are, upon the whole, satisfactory. Dr. Homen, in an interesting paper in (*Archiv für Klin. Chirurg*, Langenbeck's Journal), gives the statistics of 52 cases of empyema, treated by free incision, drainage and disinfection. Of these fifty per cent. recovered, thirty-three per cent. died, and in seventeen per cent. permanent fistulæ remained. This may be considered a fair statement of the average results obtained in general practice. The pleural fistula is in most cases, the result of the formation or existence of a cavity between the thorax and the lung, lined by soft pus-secreting tissue. This is much more likely to occur where the opening for the evacuation of pus has been made late in the disease, and where the expansive power of the lung has been impaired by the long continued pressure. The size of such a cavity, and the amount of pus discharged from the opening may vary very much, but even a moderate amount of discharge is not only a great inconvenience to the patient, but also a source of danger, by so depleting the system as to lay the foundation of amyloid degeneration of the kidney, spleen and liver, or tuberculosis. In view of these facts, it is clearly the duty of the surgeon to adopt every possible means in order to effect the closure of the cavity. In such cases Estlander's operation seems well calculated to secure the end desired. It consists in the removal of a portion of the chest wall, in order to produce a certain degree of sinking in, and allow the parietal and visceral layers of the pleura (or chest-walls and lung) to come into contact. Before proceeding to discuss the operation, its indications and contra-indications, and the after-treatment, I will report the following case occurring in my practice in the Toronto General Hospital :—

Mary B—æt 28 years, was admitted into the Hospital on the 6th of November, 1883. Parents living, family history good; has had no illness since childhood, except the present, which took place on the 28th of April, 1882, from an attack of pleurisy. She was treated by Dr. Smith, of Walkerton, who discovered fluid in the pleural cavity of

the right side on the 30th. He aspirated the chest twice during the months of May and June, removing large quantities of serous fluid. On the 8th of July, 1882, when the aspirator was again used, pus was discovered. The chest was then opened by incision and washed out daily from that time until July, 1883, when a second operation was performed in order to enlarge the opening in the chest which had nearly closed. In the latter part of August, 1883, she came under the care of Dr. Stalker, of Walkerton. He continued the treatment by washing out the cavity with a solution of salicylic acid, as carbolic acid had, on a previous occasion, produced symptoms of poisoning. From the time the first incision was made, July 1882, until the date of her admission into the Hospital, there was no appreciable change in her condition or the amount of the discharge. On admission the patient was spare and anæmic, but not extremely emaciated; appetite poor; slight hectic. The right side of the chest was sunken and flattened, causing a certain amount of lateral curvature of the spine and lowering of the right shoulder. In the axillary line, and between the sixth and seventh ribs was the opening in which a rubber tube was inserted. The amount of discharge was from two to four tablespoonfuls daily. In the upper part of the right side the percussion note was clear, but dull in the lower portion. Vesicular respiration was weak throughout, and almost indistinct in the lower part. The left lung was normal, pulse 90, temperature from 99 to 100: bowels regular, urine healthy. In the meantime the cavity was washed out daily with carbolic lotion 1 to 60, to which tincture of iodine was added. But as no improvement followed, on the 30th of November, in the presence of the members of the Hospital staff and medical students, I performed Estlander's operation. Ether was administered and the patient placed upon her left side. An incision about five inches in length was made between, and parallel to, the sixth and seventh ribs. The lower margin of the incision was drawn downwards by means of retractors, so as to expose the seventh rib. The periosteum was divided longitudinally in the median line of the rib, raised on each side, and a portion of the rib three inches long removed by means of a bone cutting forceps. The upper margin of the wound was then drawn upwards and a corresponding portion of the sixth rib removed in the same way. The pleura costalis which was much thickened, was not disturbed

except to make a larger opening by the introduction of the finger, for the insertion of a large-sized drainage tube. There was very slight hemorrhage during the operation, which was arrested by torsion no ligatures being required. The cavity was then thoroughly washed out with carbolic acid solution, a large drainage tube inserted, the wound sutured and dressed with marine tow. There was very little shock. At 6 p. m. pulse, 120; temperature, 99½; the patient felt comfortable with the exception of pain in the wound which was relieved by opiates. Without detaining you by recounting the daily history, I may say that her progress was quite satisfactory, with the exception of a rise in pulse and temperature on the third day which was readily controlled by five grain doses of quinine every four hours. The cavity was washed out daily with solution of carbolic acid, to which tincture of iodine was added; the discharge gradually diminished, and the patient's general health rapidly improved, so that she was able to leave the Hospital early in March, 1884. I have just received a letter from her former medical attendant, Dr. Stalker, in which he says, that she is greatly improved in her general health. He did not enquire as to her increase in weight since her return from Toronto, but it must



be considerable. The cavity is gradually becoming closed up, and he says he feels satisfied that in the course of a month the drainage tube now in use may be discarded, and the wound allowed to heal." Before she left the Hospital there was considerable sinking in of the chest, most marked

opposite the sixth and seventh ribs, as shown in the diagram.

The ends of the resected ribs could be distinctly felt, but the tissue between had become more or less firm, showing an attempt at reformation of bone. The patient's general condition was much improved; her appetite was better, and her anæmia had almost entirely disappeared. The report above referred to shows that this improvement has continued, and that she is now almost entirely well.

With regard to the indications for the operation it may be stated in general terms, that in all chronic cases of empyema which have resisted ordinary treatment for a lengthened period, the operation should be resorted to. It is, of course, impossible to fix a stated period, that will apply to all cases; but when a fistula has existed from six to eight months without any sign of improvement, such as diminution in the size of the cavity, or the amount of the discharge, disappearance of hectic, or improvement in the patient's general condition, this procedure should be put in practice, provided there are no contra-indications, such as advanced tuberculosis, albuminuria, or extreme emaciation. The size of the cavity may be easily determined by passing a long probe or catheter through the fistula. Estlander has shown that "even in cases of extreme debility, patients being so weak as to be scarcely able to turn in bed, the operation caused very slight derangement of the system, and was followed immediately by marked improvement. It is scarcely necessary to say that if albuminuria be present from amyloid kidney, the patient is liable to succumb to very slight shock. The operation is by no means a trying one, and may be safely resorted to in very delicate subjects."

With reference to the operation itself, the position, size and direction of the incision will depend upon the situation of the cavity and the fistulous opening. The most favorable position is upon the lateral portion of the thorax in the axillary line, the intercostal spaces being there covered by the serrations of the serratus magnus. The length of the incision and portions of ribs to be removed will depend upon the size of the cavity in the horizontal direction. For the excision of portions of two or three ribs, one single incision parallel to, and either between the two or over the middle rib of the three to be removed, will be quite sufficient. If a greater number are to be excised, parallel

incisions may be made above or below as required. The number of ribs to be removed will be determined by the dimensions of the cavity in the vertical direction. The surgeon need not hesitate to remove portions of three, four, five, or even six ribs. For obvious reasons the first and second, and the eleventh and twelfth are never interfered with. The periosteum should first be divided longitudinally along the middle of the rib, and raised from the latter before removing it. The pleura should not be interfered with, except so far as necessary to enlarge the fistulous opening, or to make a new one in the most dependent position to secure proper drainage. There is usually very little hemorrhage. After the operation the cavity should be thoroughly irrigated so as to remove any blood which may have entered during the operation. The wound should be united, drained and dressing applied. In the after-treatment in addition to the constitutional remedies which may be indicated, such as quinine, iron, codliver oil, etc., the cavity should be regularly washed out with disinfectant solutions, and the healing process may be further facilitated by the occasional use of stimulating lotions containing tincture of iodine, sulphate of zinc, etc. A favorite plan in my own practice, is to add two or three drachms of tincture of iodine to the carbolic lotion to be used for washing out the cavity. When it is found the progress of the case comes to a stand-still, which may be determined by the repeated use of the probe or by frequent measurement of the quantity of fluid injected the operation may be repeated. Occasionally great assistance in closing the cavity may be derived by the application of an elastic bandage around the chest. In conclusion I would say that Estlander's operation may be regarded as a valuable procedure in the treatment of chronic empyema, and that useful lives may be saved by the operation.

#### ANGULAR CURVATURE OF THE SPINE OF OVER TWO YEARS' STANDING.— RECOVERY.\*

BY J. CAMPBELL, M.D., L.R.C.P. E., SEAFORTH, ONT.

Mrs. B., æt. 33, a native of England, married, mother of one child, consulted me and gave me the following history. Over two years ago she felt

pain and weakness in the back while washing. "Went to a medical man and told him my trouble, and drew his attention to a small lump on my back. He did not strip my body nor examine it, but told me I would never get better. Took medicine for two years from him and during this time the lump was becoming larger and the pain more severe. Had to lie in bed the greater part of the day and could do no work." Before coming to my office she had pains shooting down the legs and was harrassed by an irritative fever. On Sept. 2nd, 1883, she came to my office and appeared to be wretched enough. From her walk I suspected Potts' curvature at once. She had a pulse of 120, with a temperature of  $101\frac{1}{2}^{\circ}$ , with a careworn anxious countenance, indicative of pain. She told me that the shaking of the buggy gave her pain and that her husband had to make the horse walk the most of the way, a distance of 18 miles. Her tongue was furred and appetite gone, hence she felt pretty weak. Stripped the body and examined the spine particularly, and found displacement three inches in length and one in depth, involving the last dorsal and first and second lumbar vertebrae. I told her that the only hope of cure was in the application of Sayre's plaster of Paris jacket, or otherwise in lying still in bed day and night, and in supporting treatment, cod liver oil, hypophosphites, etc. She chose the jacket, and accordingly on the same day, with the assistance of Dr. Scott, of Seaforth, we put on Sayre's jacket, suspending her in the usual way. She said she felt complete relief from pain, and that she could jump off the doorstep of the house immediately. After the plaster hardened I put her upon syru of fer. iod. with cod liver oil and hypophosphites, advised good unstimulating nourishment and abundance of fresh air. The first jacket was kept on six weeks. She was free from pain until the jacket began to get loose, then pain returned again. Had the second jacket put on and felt relieved as before. Kept it on six weeks also; improving steadily. She took the medicine as before. During all this time she was able to ride around in a buggy, what she had not been able to do before, as every jar gave her pain. At the end of the six weeks we put on another jacket. She did not get the same relief from this one; whether it was our fault or not, could not say. She came back at the end of one week and had another put on, which proved more suc-

\* Read before the Huron Med. Association, 8th July, 1884.



cessful, as she had complete relief from this one, and kept it on four months. During all this time she was getting stronger and was free from pain. The displacement never increased after the first jacket was put on. She came back at the end of four months and we put on the fifth jacket, which was on over three months with good results. She began working and felt pretty well. We now put on the sixth jacket, and did not see her again for ten months, but had a note from her husband stating that she was doing well. After wearing this jacket two and a half months she slit it up as we had previously directed, and laced it up in front like corsets. This enabled her to wash her body and keep herself clean. She continued taking the medicine and cod-liver oil, as previously mentioned, and improved all the time. She has gained fifteen pounds in weight, is cheerful, has no pain, and does all her own work. She came back on the fifth of June last for the purpose of getting us to put on the seventh jacket which we did. After a particular examination we arrived at the conclusion that consolidation had taken place. There was no pain nor tenderness on pressure or percussion over the displaced vertebræ, nor any other bad symptoms. She wished to have the jacket put on, she said, because she felt more comfortable with it than without it. It looked to her like an old friend, and she did not wish to part with it. The cure may be considered complete, and it is not likely that another jacket will be required or asked for even for friendship's sake. In fact we did not think the last was required, but put it on at her own request as we knew it could do no harm, and it is always better to err on the safe side at any rate.

**Remarks.**—My reasons for reporting this case are the following :—1st. I had a conversation with an old pupil of Dr. Stewart, of Brucefield (who introduced Sayre's jacket into this county, and who probably put on more jackets than all the doctors in it), and this gentleman said that he never yet knew of a cure from it, and he only knew of one case that was benefited by it. Now, I thought, if that be true, I must report my case, which is undoubtedly a complete cure. 2nd. When we consider the age of my patient, namely, 33 years, the cure is the more remarkable, as I believe it is conceded that the older the patient the less chance there is of receiving benefit, and that after twenty

years of age the prognosis is rather grave. 3rd. My patient was over two years ailing before I saw her. The disease was very pronounced, as this report shows, and the woman in a miserable condition, all of which things were against us, for all will agree that the sooner a case of this kind is diagnosed and treated the better. 4th. The relief was instant, which in itself was worth a great deal, even if she had not recovered, and the improvement, though gradual, continuous, until the consummation so devoutly to be wished was finally arrived at.

### CARBOLIC ACID IN PURULENT AFFECTIONS OF THE CONJUNCTIVA AND CORNEA.\*

BY G. HERBERT BURNHAM, M. B., F. R. C. S. EDIN.,  
M. R. C. S., ENG., TORONTO.

Late Resident Surgeon to Moorfield's Eye Hospital, London.

A few years ago when Resident Surgeon to the Moorfield's Eye Hospital, London, I introduced into ocular practice the use of the 5 per cent. lotion of carbolic acid in gonorrhœal ophthalmia. Previous to this I had tried every variety of treatment then recommended with a success not very encouraging.

The deep transparent excavations of the cornea so frequent in this affection, so often followed by perforation and prolapse of the iris, or deeply infiltrated ulcers which, through leaking in their floor, give rise to falling forwards and adhesion of the iris to the posterior surface of the cornea not again to be loosened; or other cases in which the ulceration rapidly involved the whole cornea, causing destruction of vision, and at times of the eye itself—all these terminations have I at different times witnessed and seemed powerless to prevent. If the changes did not go so far, still I have been kept on the wings of expectation, not knowing, with the arsenal of remedies then at my command, what the outcome might be. These are a few of the considerations which made me anxious to get a better and more reliable remedy. Now, after a considerable lapse of time, I feel that I have secured the desired remedial measure in carbolic acid. I have tested its merits in all the various forms of gonorrhœal ophthalmia, for instance, in

\* Read before the Ontario Medical Association, June, '84.

that with much serous chemosis and swelling of the ocular and palpebral conjunctivæ; in that where the œdema is as great, but harder and denser; in that where the conjunctivæ of eyeball and eyelids and the sub-conjunctival tissue, are so fully loaded with exudation as to give the brawny, mottled look of diphtheritic ophthalmia. In fact, quite lately, I had a case, that of a young man, in whom the inflammation was the most violent I ever witnessed. The partly everted lids had the mottled, white and red look with inability to remove any of the infiltrations so characteristic of diphtheritic ophthalmia. When the tissues began to unload themselves, quite large pieces came away leaving excavated and bleeding surfaces. I value the treatment by carbolic acid so much above all the other varieties that I have ever employed, that I now use no other. Under its influence, the transparent excavations quickly heal, and, moreover, have never, since I began its use, progressed to perforation, as formerly so often the case. The same may be said with respect to the other forms of corneal ulceration brought to our notice in gonorrhœal ophthalmia.

I, however, met with one form of corneal mischief, which I do dread, and against which I am not as well provided, as I could wish. This form is the deep, circumscribed infiltration of the cornea with the external surface unabraded. Here the morbid process goes on extending inwards till hypopyon comes. After this the external surface ulcerates, and then the part is so weak, that at once perforation of the cornea and entanglement of the iris, more or less complete, take place. The powerlessness of carbolic acid in this variety is due to its inability to reach the seat of mischief. The consequences of these cases being such as I have mentioned, have determined me to do *Saemisch's* operation when the opportunity is given me, and by so doing bring the abscess under the benign influence of this acid. This action I shall take though well aware of the great danger of incising the cornea in the midst of such a fierce purulent discharge. As is well known in the worst forms of gonorrhœal ophthalmia the lids are so swollen and stiff, that only very partial or no eversion can be made. This prevents the proper application of other forms of treatment, such as strong solutions of nitrate of silver, the mitigated and pure stick. The carbolic acid lotion travels with great ease

beneath the lids, and hunts out as it were all the obscure places. The way in which to make such a thorough application can, after a short time, be taught any moderately skilful nurse. These last truths I consider of great moment, and factors telling much in its favor.

The course pursued in the treatment of a case of gonorrhœal ophthalmia is as follows: The patient is ordered to bed; then there is placed at his bedside a large basin of cold water in which there is always kept a big piece of ice. The eye is to be bathed by the patient, or by the nurse, very frequently so as well to cleanse the eye. In the intervals cloths wet in the iced water are constantly to lie upon the closed eyelids. The lotion of a strength 1 in 20, is to be thoroughly applied *every hour*, the lids being as well everted as possible. I always apply the lotion very freely, and at the same time tell the patient to move the eyeball about, so as to give the lotion as free access as possible. These applications are to be made day and night. In consequence of this a nurse must be in constant attendance. The pain and smarting, which ensues after using the carbolic acid, last but a few seconds, and are succeeded by a feeling of comfort and relief. This is another point in its favor, and in direct contrast with the effects of the powerful caustics heretofore employed. As the discharge becomes thinner and more laudable, the 5 per cent. lotion is to be used every second hour, and during the intervening hour, the 2½ per cent., or 1 in 40, is to be applied. As the virulence of the affection goes on diminishing, the 1 in 40 may be used altogether. I do not employ the watch glass protector, the ingenious contrivance of Dr. Buller, of Montreal, for the sound eye. I tell the patient to lie on the side on which the affected eye is, and warn him of the danger of inoculation. I consider these measures to be sufficient precautions when using so frequently an application of such strong antiseptic properties. I look upon this lotion as the most effective and reliable remedy we have at our command in gonorrhœal ophthalmia; and the more I make use of it, the greater becomes my faith in its power for good. The great *antiseptic* and *astringent* properties of carbolic acid place it, in my opinion, without a rival in the treatment of this inflammation.

This is its history in my hands with regard to the foregoing affection. I shall now mention it

with respect to other purulent affections, especially where the cornea is markedly implicated. One of the most dreaded sequels to a cataract extraction is purulent infiltration of the corneal wound. When this infiltration of the cornea has made its way to *Descemet's* membrane, and is also spreading in other directions in the corneal substance, and is associated with free purulent discharge, there is a feeling in the mind of the operator that the eye is as good as lost. It is in just such cases that I have more than once been completely successful, and have secured an unimpaired eye. I well recollect one case, that of an old and feeble man, an inmate of Moorfield's Eye Hospital, in whose eye on the third day after the operation, when union had taken place, infiltration of the wound set in. This, under the usual mode of treatment in such cases, got worse and worse. The infiltration alarmingly increased in depth and width, and the discharge became markedly purulent and copious. It was quite evident that improvement must quickly take place, or the eye would be lost. I now vigorously applied the 5 per cent. carbolic acid lotion. The result was that in two days the eye was out of all danger. Then, on examining the wound, there was to be seen a deep, broad excavation reaching to *Descemet's* membrane, with a ragged but healthy surface. The surrounding cornea was bright and clear. This excavation gradually filled up, and the patient went out with a good, serviceable eye. In those cases of kerato-iritis, where the corneal ulceration is extensive, this lotion has been used with most beneficial results. Here it is combined with the usual treatment of atropine, warm bathing and constitutional remedies. I have based all my remarks upon those cases in which the corneal inflammation was extensive, and associated with more or less purulent discharge, and where a new departure in treatment would show its usefulness, and enable a just conclusion to be drawn, in other words in test cases. If I think a weaker lotion than the 5 per cent. will answer the purpose, I may not at any time use the 5 per cent.

I feel that I am fully justified in strongly recommending the carbolic acid lotion in the various and kindred affections laid before you; for it has so often come out victorious in real test cases, and where previously non-success had too often been my lot. It is very necessary to use the *pure* carbolic acid, as any impurities give rise to such irritation and sometimes pain, as not only seriously to interfere with its full and proper application, but also materially to lessen its curative properties.

## Correspondence.

To the Editor of the CANADA LANCET.

SIR,—Since reading an article in the December No. of the LANCET under the caption of "Professional Advertising," anent "our confreres down by the sea," I felt constrained to bring the following case of unprofessional conduct under the notice of the profession. Dr. A. is attending Mrs. S.; Dr. B., passing by, interviews Mr. S., and gains admission to the patient by the consent of the husband and without the knowledge of Dr. A. Dr. B. (by force of habit perhaps) finds fault with the diagnosis and treatment of Dr. A., and by fair promises gains the confidence of the patient, and takes the case. Dr. A. visits his patient next day, is astonished at the conduct of Dr. B., and leaves in disgust.

This individual is also in the constant habit of visiting the patients of other medical men in their absence and without their knowledge, and attempts to justify himself in some cases on the flimsy pretext that he was requested to do so by the friends of the patient. He also habitually volunteers his advice and opinions concerning the patients of other physicians solely upon "hearsay" evidence. When called in consultation it is his custom, when opportunity presents, to remain behind and converse with the relatives of the patient after the attending physician has retired, and by innuendoes and insinuations infer that the case has not been properly treated, though no such inference was made in the presence of the attending physician. This conduct is of frequent occurrence in the practice of an old established physician here, who, to keep the vituperations and slanders against other medical men fresh before the public, is generally accompanied by his helpmeet.

Your, etc.,

A RESIDENT PHYSICIAN.

Cornwallis, N.S.

## Reports of Societies.

SARGEON AND BROCK MEDICAL ASSOCIATION.

A meeting of the Territorial Association of the Sargeon and Brock Division was held in the town of Harriston, on the 8th day of January, 1885. The following resolutions were carried:

That all the proposed amendments to the Medical

Act, except clause 4, meet with our approval, and that instead of appointing a taxing officer, this meeting recommends the adoption of a uniform tariff for the whole Province, legalized by the Medical Council, signified by the Seal of the College, and the signature of the President, as provided in Section XVI. of the Ontario Medical Act.

That all Medical Students, after the year 1887, shall be required to matriculate and attend a course of at least two full sessions in the Arts department of some University recognized by the Medical Council.

That the members of this Divisional Association, now assembled, desire to express their approval of the course pursued by the Medical Council, and also of their present representative, Dr. Douglas, during the past five years.

Referring to the tariff lately issued by the Grand Trunk Railway, as regards medical attendance upon their employees and passengers: That the medical tariff rates issued by the Grand Trunk Railway be disapproved of, and that we recommend that no medical practitioner in this Division do sign it.

(Signed)

R. DOUGLAS,

*Chairman.*

LLEWELLYN BROCK,

*Secy. Treas.*

## Selected Articles.

### THE METHOD OF EXAMINING ABDOMINAL GROWTHS.

The following clinic by J. Ewing Mears, M. D., Jefferson Medical College, reported in the *Med. News*, will be read with interest:

The presence of this patient to-day affords me the opportunity of speaking to you with regard to the methods to be pursued in the examination of patients suffering from abdominal growths. Having the patient prepared in this way and placed on her back on the table, the first step in the examination is inspection.

*Inspection:* The surface of the abdomen is inspected in order to ascertain whether it is uniform in shape. Its contour is observed and any enlargements or projections are to be noted. In practising inspection we should note not only any irregularities of the surface, but also the condition of the integument and any marks which may be found in the integument. For instance, your at-

tention is called to a line which frequently exists between the umbilicus and the pubes. Formerly this line, which has a brownish color, was regarded as diagnostic of pregnancy, it being usually found, or almost as a rule, in women who are pregnant. This line is also observed in the patient before you and I have seen it in a number of cases of abdominal tumors. It is, therefore, not pathognomonic of pregnancy, but it also exists in other cases of enlargement of the abdomen. This line is due to a pigmentary deposit, and, so far as I can recollect, I have never seen any satisfactory explanation why it should exist. In a recent case of ovariectomy not only did this line exist prominently between the umbilicus and the pubes, but brownish spots were also found on different parts of the body, face, chest, and right side of the surface of the abdomen and on the lower extremities. In this case the patient stated that the brown line and spots appeared after the development of the growth. Further, after pregnancy to full term has occurred, the surface of the abdomen may be marked by cicatrices, which indicate undue stretching of the integument. I call attention to this point, since it has happened in cases which have been presented at the clinic, that pregnancy has occurred in unmarried females and the history of the case has been entirely opposed to any such condition.

Having learned all that we can from inspection, the next step in the examination is palpation.

*Palpation:* By palpation we mean pressure with one, two, or three fingers upon the abdomen, carrying this, if necessary, to some depth. In order to facilitate this manipulation, it is desirable that the patient should be directed to inspire and then make a forcible expiration. By this means the diaphragm is drawn up and the walls of the abdomen are relaxed and deep palpation can then be made. By means of palpation we ascertain whether the cavity of the abdomen or the cavity of the pelvis is occupied by a growth, and, further, whether the growth is hard, soft, or elastic.

*Percussion:* The next step is to percuss the abdomen. Percussion is familiar to you all as one of the methods employed in the examination of the thoracic cavity. Beginning in the median line, we percuss downward from the ensiform cartilage to the umbilicus and pubes. The patient is then turned on her left side and percussion made over the right lumbar region. She is afterwards turned on the right side and the left side percussed in a similar way. Percussion gives us an idea in regard to the character of any growth in the cavity of the abdomen. The percussion note obtained over the intestine is resonant, or even more than resonant, tympanitic in character. Over a solid tumor the percussion note would be dull or flat. Over a cyst containing fluid it would also be dull or flat. By percussion, therefore, we determine whether the abdominal cavity contains anything more than the

intestines, which emit a resonant or tympanitic sound on percussion, and the extent to which the growth occupies the cavity.

**Auscultation:** Auscultation is also to be employed in the examination of abdominal growths. In carrying out this procedure it is necessary to apply the ear to different parts of the surface of the abdomen. If there is any reason to suspect pregnancy, the ear should be first applied over the left side of the abdomen, midway between the umbilicus and the middle of Poupart's ligament. At this point the foetal heart sounds can usually be heard, if the embryo occupies what is considered its normal position, that is, with the vertex to the left. Auscultation also enables us to determine whether or not the swelling which is present is due to aneurism, for by this means the presence of the aneurismal bruit can be determined.

The effort to determine *fluctuation* is the next step in the examination. By this is meant the production of a wave through the mass of fluid when the walls of the abdomen are struck or percussed. If one hand is placed on one side of the abdomen, and the other side is percussed with one or two fingers of the other hand, the movement of the fluid is felt distinctly. This wave differs much in amplitude according to the density of the fluid and also according to the character of the cyst in which it may be contained. If the fluid is thin and limpid, the wave is long; if the fluid is very dense and viscid, the wave is short. The ability to determine these differences is acquired largely by experience. I simply give you here general statements in regard to the differences in the fluctuation wave in fluids of different density. Fluctuation also enables us to a certain extent to determine whether the fluid is contained within a cyst or in the general peritoneal cavity. This also requires some experience in order to insure accuracy. Fluid in the general peritoneal cavity gives in fluctuation a wave which pervades the entire cavity, and this can be felt by placing the hand on different parts of the surface. When, on the other hand, there is even a thin cyst wall it is sometimes possible to distinguish the limit of the wave movement. Fluctuation can also be developed by introducing a finger into the vagina, and if the cyst occupies the pelvic cavity, fluctuation can be obtained by percussing the abdominal wall and feeling the wave with the finger in the cavity of the vagina.

I desire also to call your attention to a wave-like movement which is sometimes obtained on percussing the abdomen, and which is known as the fat wave. This wave is found in patients with very fat abdominal walls, this fat being loosely held in the meshes of the fascia. It is important that this be borne in mind, for errors in diagnosis have been made by the confusion of this wave with that of fluctuation.

We have so far examined the abdominal surface. It has been examined with the eye so as to determine its contour and outline. It has also been examined by palpation and percussion. The ear has been placed on the surface and auscultation has been performed. The effort has also been made to determine whether the fluid is contained within the peritoneal cavity or in a cyst in the cavity. This has been done by eliciting the fluctuation wave.

I might say, in addition, that it is desirable to employ mensuration—that is, measuring the enlargement. This can be done by a tape-measure passed around the abdomen at the level of the umbilicus. Then, at the point of the ensiform cartilage, also at the point of greatest enlargement, which is usually below the umbilicus, and a measurement may also be taken just above the pubes. In this way the circumference at these various points can be ascertained and recorded. It is also important to note the distance from the ensiform cartilage to the umbilicus and from the umbilicus to the pubes. If it is necessary to examine the patient from time to time, these measurements can be repeated in order to determine the variation in size.

Having completed the external examination, we are now prepared to make a vaginal examination. I take the opportunity of saying at this point that no one would be justified in undertaking abdominal incision without completing any examination which has been made by a vaginal examination. I can recall at this moment one case in which this step was neglected and the abdominal cavity was opened and a pregnant uterus found. A vaginal examination in this case would undoubtedly have revealed the existence of pregnancy, and the patient would have been saved the rather dangerous operation of abdominal incision. For the purpose of a vaginal examination the patient should lie on her back and should afterwards be changed to the side. The finger, well anointed, should be passed into the vagina and at once seek the cervix. Having examined the cervix, the finger should be swept around the neck, and as it is withdrawn palpation should be made anteriorly, laterally, and posteriorly. Then bimanual examination should be practiced, with the finger of the right hand in the vagina, pressure being made over the surface of the abdomen with the left hand. In this way information can be obtained in regard to the connection of the growth with the uterus. Other points of information which can be obtained in this way are the following: A cystic tumor occupying the pelvic cavity can be felt through the vaginal wall. A solid tumor can be felt in the same way. So with the finger introduced into the vagina, the occupation of the pelvic cavity can be determined through the vaginal walls. As I have already stated, fluctuation can be obtained with the finger

in the vagina, percussion being made on the surface of the abdomen with the other hand.

It is also necessary to introduce the sound into the uterine cavity in order to determine the condition of the uterine canal. It is desirable that beginners in performing this operation should use the speculum. After years of experience, one may be enabled readily to introduce the sound without danger into the cavity of the womb without a speculum, the finger of one hand being introduced into the vagina and placed on the cervix and the sound being carried along this as a guide. There are so many dangers, however, which present themselves in the introduction of the sound in cases of uterine tumors, that it is desirable to use the greatest care in the introduction of the sound into the canal. It should not be forced, but the way should be felt. It frequently happens that there are displacements of the uterus by reason of the pressure of the growth, whether this be solid or cystic in character. With regard to the presence of cystic growths, the information obtained by passing the sound into the uterus relates rather to the mobility of the uterus and to the fact of its being drawn up from the cavity of the pelvis or forced down into the cavity. On the one hand, we may assert with reasonable accuracy that adhesions exist if the uterus is found to be drawn up into the cavity of the pelvis and held in a fixed position; and on the other hand, we may infer that the cyst is impacted in the cavity of the pelvis, if the uterus is in a state of flexion, either antero or retro, and is immovable in its position. In fibroid growths, especially of the submucous and mural varieties the sound will give valuable information as to the seat of the fibroid tumor.

With the speculum we can ascertain the color of the mucous membrane of the vagina and the color of that covering the cervix. This is regarded as a matter of importance, as in the pregnant female the color is of a purplish hue, which is thought to be diagnostic. Another point to be ascertained with the finger in the vagina is the condition of the cervix, as to softness or hardness.

In addition to the examination by the vagina, it is sometimes desirable to make an examination by the rectum. By this means the existence of growths which cannot be readily reached in the vagina can be determined. An enema should be administered beforehand in order to unload the lower bowel.

It is also well to complete the examination by the introduction of the sound into the cavity of the bladder. With this instrument in the bladder, and the finger in the rectum, bimanual manipulation can be made which will assist in the detection of tumors occupying the pelvic cavity.

In order to illustrate the points to which I have alluded, I shall next examine the patient now upon the table. She has been prepared by the removal of all unnecessary clothing and of all constrictions

around the waist. The abdomen is exposed, and on inspection we observe that it is irregular. In the median line there is a projection, and on the right side there is another. The observance of two irregular points upon the surface gives us certain information in regard to the nature of the growth which occupies the cavity of the abdomen. It excludes certain conditions. For instance, pregnancy. In pregnancy there is a uniform enlargement of the abdomen, and the surface is not irregular as in the present instance. Inspection does not enable us to say whether these irregularities are due to pedunculated fibroid tumors or to exogenous cysts forming part of an ovarian cyst, but it does enable us to say that this is not a case of pregnancy and not a case of simple cyst.

Palpation is the next method to be employed. By making pressure with two or three of the fingers over different parts of the swelling, I can easily feel beneath the abdominal wall a hard, resisting mass which is not elastic. This would seem to indicate that the growth is solid and not cystic. Palpation elicits the same sensation over all parts of the growth. We cannot say positively from this examination that this is not a very dense multilocular cyst. You may be able, after much experience, to determine very slight shades of difference in the elasticity, which can be obtained even in cases of dense multilocular cysts. So far as I can ascertain from palpation, I am inclined to believe that we are dealing with a solid tumor and not a cyst. Not only do the fingers determine the presence of a hard, unyielding mass, but those projections which were noticed on inspection can be further outlined. Slightly to the right of the median line is a large mass which appears to be attached to the uterus by a broad pedicle. On the left is another mass, and below the tumor on the right there is a small mass which seems to be somewhat moveable. This would seem to indicate that these growths are fibroid tumors which are attached to the body of the uterus by either broad and short or narrow longer pedicles. In the former case being called sessile and in the latter pedunculated or pediculated growths.

You will observe that the brownish line reaching from the umbilicus to the pubes, which has been referred to, is present in this case.

Next, I shall practice percussion. Beginning at the ensiform cartilage, and percussing in the median line, there is, as you observe, resonance down to this point, about two and a half inches above the umbilicus. Here the sound suddenly changes into that of dulness or flatness. As I pass downward in the median line, the same flat sound is elicited below the umbilicus. As I pass on either side of the median line from the point before mentioned, the dulness is found to exist there also. The patient is next turned on the left side, and percussion performed over the right lumbar region and

lateral side of the abdominal cavity. At this point we find the dulness which belongs to the liver, and as we pass downwards we reach the resonance belonging to the ascending colon. Turning the patient now upon the right side and percussing over the left side, we find in the posterior part of the lumbar region, the resonance depending on the presence of the descending colon. As we come to the median line, the sound becomes dull or flat, showing that this mass projects more into the left side than into the right side of the abdominal cavity.

Testing for fluctuating, I find it impossible to obtain any wave. We can therefore say that there is no fluid, either in the abdominal cavity proper or in any cyst contained in the abdominal cavity.

Continuing the examination, I place my ear over the abdomen at the point which I have before mentioned. I am, however, unable to hear any sound which may be regarded as indicating the presence of a fœtus in the uterus or any aneurismal bruit which would be found in dilatation of the aorta. Auscultation, therefore, gives altogether negative signs in this case.

Examination per vaginam shows that the uterus is small. The cervix is slightly elongated and that of a woman who has not been pregnant. The uterus is fixed and immovable in a position of marked retroflexion. Palpation through the vaginal walls reveals the presence of hard, unyielding masses. These, so far as can be ascertained, are attached to the body of the uterus. Owing to the displacement of the uterus, it is impossible to introduce the sound completely. It simply passes into the cervix, but not beyond the internal os.

Rectal examination has not been made, nor has any examination by the bladder been made, as the symptoms were sufficiently prominent and characteristic to enable us to arrive at a conclusion without employing this manipulation. In any case of doubt, however, it is necessary that examination by the rectum and bladder should be made as before stated.

Having passed in a systematic manner through the different steps of the examination, we are enabled to arrive at a conclusion in regard to the nature of this growth. In other words, we are prepared to make the diagnosis. From what I have seen, and from what I have felt, I am prepared to say that we have here fibroid tumors which are of the subperitoneal form. Whether the uterus itself is involved to any great extent cannot be positively determined, owing to the impossibility of introducing the sound. It is, however, quite possible that in addition to the subperitoneal form of fibroid tumors there is also the mural form or that in which the body of the uterus is affected.

Before passing to the question of treatment, I would say that there are three varieties of fibroid growths, or if you choose to call them so, of fibro-

myoma or fibro-myomatous growths. These varieties are the subperitoneal, in which the tumors lie beneath the peritoneum; the interstitial or mural, in which the tumors are located in the substance of the uterus itself, and the submucous, in which the tumors are situated beneath the mucous membrane of the uterine canal. In the subperitoneal variety the tumors project from the surface of the uterus, being covered with a layer of peritoneum and sometimes attached to the body of the organ by a broad and short pedicle, in which case, as I have said, they are called sessile growths, or by narrow and long pedicles, in which case they are called pedunculated growths. In those cases in which the pedicle is small and long, the mass can readily be moved about the cavity of the abdomen. Not only so, but it falls about if no adhesions exist, as the patient changes her position from side to side or rises from the recumbent to the erect position. In the case of mural tumors, which, as already stated, occupy the substance of the uterus, the organ is uniformly enlarged. Where they exist without the presence of subperitoneal or submucous tumors, the uterus is uniformly enlarged, as is found in pregnancy. In the submucous variety the growths form beneath the mucous membrane and project into the cavity of the uterus. Sometimes they get into the canal, and the contraction of the muscular fibres forces them on down until they escape from the cervix, forming what are known as polypi, the pedicle being in these cases elongated so as to permit the growth to pass into the cavity of the vagina. Frequently these submucous fibroid tumors are very large, and they do not pass into the canal and become pediculated, but distend the cavity of the uterus and change the direction of the canal.

The symptoms in the submucous and mural varieties of fibroid tumors are largely connected with the menstrual flow, and they relate to an increase of the flow. I have had some patients who have lost enormous amounts of blood at these periods. This is a prominent symptom and should always lead to a suspicion of this form of growth. Hemorrhage at the menstrual period is not so marked in the mural as in the submucous variety. This symptom may be entirely absent in the subperitoneal variety of fibroid tumors.

I next come to the question of treatment. At the present day, various methods of treatment are practised. In the first place with regard to medication. Mural and submucous growths are amenable to treatment by means of such remedies as ergot, which, by contracting the bloodvessels of the organ, diminish the nutrition, and in that way limit the growth of the tumor. There has been sufficient experience obtained in the use of ergot and its preparations to warrant the conclusion that these forms of growth can be positively limited. Whether or not they can be ultimately removed, is still a question, but their growth can be checked. Ergot



is not of as much value in the subperitoneal variety, especially in the pedunculated form, where the pedicle is long and narrow. It may be of some service where the pedicle is broad, as in the sessile growths, and where the effect of the remedy can reach the bloodvessels of the attached mass. The muriate of ammonium was employed by the late Dr. W. Atlee, who regarded it of value in the treatment of fibroid growths of the uterus.

After these remedies, operative interference may be employed, but there are two very important questions or conditions to be considered before any operation is to be decided upon. In the case of fibroid growths in which the menstrual flow is so great as to drain away the life of the patient, it may be justifiable to interfere with the knife. There is also another condition which would warrant operative measures, and that is the enormous size of the mass, making it a burden to the patient too great to bear.

In regard to operative interferences, the menopause can be anticipated by the removal of the ovaries. If any operation is to be performed, the removal of the ovaries, which is much less dangerous than extirpation of the uterus, is the one to be adopted. There are to my mind very grave objections to the performance of operations for the removal of fibroid masses which involve the body of the uterus or which are attached by very broad pedicles to it, and which are adherent to the viscera or abdominal wall.

A patient with a uterine fibroid can enjoy life and the growth can exist indefinitely without interfering with health. I have at this time under my care a number of patients suffering from fibroid tumors in whom I have practised the hypodermic injection of ergotine, or the aqueous extract of ergot, for a number of years. In one of these cases, I have used ergotine for the past eight years. Measurement of the abdominal enlargement in this case shows that the growth has not increased. It has, on the other hand, not markedly decreased. The patient does not lose much blood during her menstrual period, and is not rendered uncomfortable by the presence of the tumor. She is able to take part in all the enjoyments of her home, to ride out in her carriage, and to enjoy the company of her friends. I am quite sure that if I were to interfere in this case with a surgical procedure, I should terminate the life of my patient. In another case, in which I used ergot for three years, a most desirable result was obtained. In this instance, the growth was of the submucous variety. After the lapse of nearly three years, I observed that the mass was softening; and on palpation and percussion, fluctuation could be distinctly obtained. I also examined the mass from the cavity of the uterus, and found that there, too, it was softened, and fluctuation could be obtained. I therefore determined to incise the wall of the canal, which I

did, and a mass of offensive fluid escaped, containing broken down debris of muscular and fibrous tissues. My patient suffered greatly from pyæmic symptoms, and was very ill for a number of days; but by the vigorous use of antiseptic methods, washing out the cavity with antiseptic agents, as the solution of carbolic acid, surrounding her with the best hygienic conditions, and by the employment of tonics and stimulants, I was able to carry her through this critical period occupied by the evacuation of this large cavity formed by the breaking down of the tumor. Other instances of this kind have been recorded in which the effect of ergot was markedly seen. I can only explain this transformation of the solid growth to the fluid or semi-fluid condition by the cutting off of the nutrition of the growth, and the production of positive gangrene.

There are instances on record in which incision of the lining membrane of the canal has been made and ergot afterward given. In this way submucous fibroid tumors have been delivered. When the delivery has not been complete, the surgeon has interfered, and has removed the mass by cutting away portions of it at different times. This operation is attended with many dangers. Some of these dangers result from septic infection and shock. There is also the danger of the occurrence of hemorrhage.

From the examination of the case before you, the treatment which I should adopt, would be the long continued use of hypodermic injections of ergotine, and this failing, the performance of oöphorectomy. I may say, in regard to the hypodermic injection of this remedy, that the injections should be made in the abdominal wall; and in order to avoid the occurrence of abscess, it has been my practice to carry the needle of the syringe deeply into the tissues, not stopping until the muscular structures have been reached. In none of the cases in which I have used ergotine in this way have I met with abscess. As a precaution I have frequently painted tincture of iodine around the puncture made by the needle. The form of ergot used is that known as Squibb's aqueous extract, made in a solution, the strength of which is one grain to the minim. Of this solution, I have given 25, 30, and 35 minims without producing any undesirable symptoms.

#### THE TREATMENT OF HYPERPYREXIA BY COLD APPLICATIONS TO THE ABDOMEN.

In a recent clinic in the *Pennsylvania Hospital* reported in the *Col. and Clin. Record* Dr. Da Costa gave the following interesting cases:

The case now before you is one of typhoid fever, only remarkable for a sustained high temperature

persisting in spite of various remedies. The temperature in the morning was  $103^{\circ}$  F., and occasionally  $102$ , in the axilla, but for nearly a week the temperature remained at  $104.8^{\circ}$ . As there had been no marked exacerbations in the temperature, we looked upon it as a case of grave character, on account of the sustained fever. With reference to the intestinal lesions, as manifested at least by the occurrence of symptoms of bowel disorder, they were not severe: he had only three or four stools a day. The eruption was well defined, but there is nothing in the case to which I wish to call your attention besides the temperature record.

Let us see his present condition. His temperature this morning is  $100\frac{1}{2}^{\circ}$ ; last night it was  $101\frac{1}{2}^{\circ}$ . I, therefore, think that the disease is yielding. The bowels have not been opened for thirty-six hours, and tend to constipation. He is very deaf, but obeys intelligently when I can make him hear. His tongue is moderately dry and slightly fissured; it is tremulously protruded. I want you to observe this cracked, dry condition, with the yellowish coating upon it; though it is not very dry, it still impresses you as a dry tongue. His abdomen is rather prominent and tender; a few spots of eruption are still visible upon the surface. There has been some atony of the bladder, so that the urine has had to be frequently drawn with the catheter. Examining his heart, I notice that there is almost complete extinction of the first sound; it can just barely be heard. The pulse beats only one hundred in the minute, even with the excitement of coming before you; but, as I see upon the record, it has never been a rapid pulse. It is compressible, but has decidedly more volume than it had a few days since. His general condition is improving with the reduction in the temperature. He has been taking dilute muriatic acid (gtt. v) and turpentine (℥ x) every two hours. He also takes twelve grains of quinine daily; and six ounces of wine and six of whiskey; therefore he is freely stimulated. His food consists of milk and beef tea, two pints of each in the twenty-four hours.

Now I have given you a statement of his treatment, with a single exception, and that is what I wish to develop in our discussion, viz.: the treatment of the high temperature. When I found that this man had, a week ago, an evening temperature remaining persistently at  $104^{\circ}$ , I tried to reduce it by large doses of quinine, sixteen grains daily; and on one day he took ten grains morning and evening. He was also frequently sponged with cold water. The effect was but slight; the temperature remained high. I then directed that cloths wrung out of ice water should be laid upon the abdomen until the desired result was obtained. It was found that this was more efficient, and the temperature was at once reduced to  $100^{\circ}$ , so that by this means we were enabled to keep the temperature within bounds, and thus to gain time. We discussed the

expediency of putting him in a bath, but, as he was very weak, and the bath room is some distance from his bed, rather than subject him to the risks of so much handling, we yielded the point, though, if the bath had been more convenient, I would have preferred it. I wish to call your attention especially to the use of ice water applications to reduce temperature, as a substitute for the large doses of quinine, and cold baths, which are not always convenient. It is a most instructive case. Indeed, I consider that the man's life has been saved by this means. Taking into consideration the rising temperature and the failing circulation, as shown by the impaired heart sounds, it did seem likely that the case would not get well. I would call your attention to the fact that in this case the quinine failed to reduce the temperature. It does not often fail, but it did here.

Another point is this deafness which you have observed. I almost had to shout to him before he put his tongue out. The resident physician tells me that he has been so since he came in; therefore it was not the effect of the quinine. Deafness in typhoid fever is not uncommon, and I may state that it does not contradict the use of quinine; by no means. It is due to the state of the blood and the impaired nervous system. We also note here that he has a constant tendency to stupor, is rather drowsy and heavy; he sleeps well at night without opium; he has not been delirious, and has not suffered with headache. The deafness, therefore, is the only symptom referable to the nervous system. There is very little if any, jerking of the tendons, or tremor.

Now, gentlemen, with regard to the treatment I shall make a slight modification. Quinine need only be given in tonic doses. We will order him to take eight grains daily. The dry tongue indicates that the turpentine is still useful; the amount of acid is so small that it does not make much difference whether it be continued or not, but, as it is grateful to the stomach and aids digestion, we will continue it also. Sponging of the general surface with water will be done several times a day, as heretofore; and if the temperature again rises we will return to the ice water applications. With regard to the amount of stimulant, although it seems large, yet I will not reduce it, on account of his dry tongue and weak heart. I think that just now it would be dangerous to make any change.

#### PILOCARPINE IN ACUTE ERYSIPELAS.

I have here a case to show you which I think will interest you, as it brings out rather a novel treatment of erysipelas. I intended to exhibit this to you this morning as a case of erysipelas, but I find that the erysipelas has gone. I, therefore, can only speak of the treatment, which has proved more quickly efficacious than I supposed it would.

This man B. K., 32 years of age, a fireman, was

admitted only yesterday. This is the record upon admission: "He says that he was quite well yesterday (November 12), but he did not go to work, as he was celebrating the election. In the evening, according to his statement, he was not drunk, though he had been drinking a little, and became engaged in a very earnest political discussion, when some one, equally earnest, struck him in the right eye, making a bruise on the cheek and a small lacerated wound on the eyebrow," the evidence of which you may see for yourselves. The man at that time was quite well, although under the influence of liquor. "During the night he had much pain in his eye, and in the morning the eyelids were oedematous and the cheek likewise swollen, red and burning." When he applied for admission the inflammation was confined to the right side of the face, but it spread rapidly, and the same afternoon both eyes were closed. It is worth adding this to his history that he had slept out all Wednesday night after receiving the injury. He was admitted on Thursday morning, with erysipelas of the upper part of the face, which was rapidly spreading over the brow. His pulse was 80; temperature, 102.8°; respiration 22. The urine was examined, with a negative result. He was ordered tincture of the chloride of iron, twenty drops every three hours, but only received one dose; as the disease was rapidly spreading, and something was needed to make a prompt impression, I used another and more active agent. This was not the first case in which I had used this remedy, but it was the first in which I obtained such rapid relief. He received, hypodermically, one-sixth of a grain of the muriate of pilocarpine. The result was remarkable. Here is the temperature record: the temperature fell from 102° to 99¼°. He sweat profusely for an hour and a half, and there was no further development of the erysipelas; not only did it not spread further, but what did exist quickly subsided. No local treatment was employed, not even cold applications; therefore, whatever success was obtained was from the pilocarpine.

I call your attention to this treatment of erysipelas. I said that it had not been my first case, although it was the most striking case I have seen. As long as five years ago I used jaborandi in the treatment of erysipelas until sweating was produced, and, I thought, with the result of checking further development. In one case with high temperature the disease had already made some headway, and did not subside so quickly. Under the use of iron the disease had not been controlled, but the fluid extract of jaborandi, given every two hours, checked it. I have since used the jaborandi in connection with the iron at times, with good results. This is, therefore, not a new treatment with me, as I have used for some time. Jaborandi and pilocarpine, its active principle, are, of course, similar in their effects.

I have called your attention to this treatment, not because I believe that it will be followed by the same result in every case, but because it is worthy of a trial. If you get a case of erysipelas in its beginning, use pilocarpine. It has saved this man a long and dangerous illness, and, as he had been drinking, as he said he had, the results might have been serious. In the use of this treatment it should be borne in mind that, in order to be fully effective, profuse sweating must be produced.

### MALARIAL SYMPTOMS FOLLOWING SURGICAL OPERATIONS.

M. Verneuil has already called attention to this subject, which is one that should be of special interest to New York surgeons, seeing that it is the fashion in this city to ascribe to "malaria" a number of obscure symptoms which can not be conveniently assigned to any other cause. Dr. Baruch has alluded to the fact that much of the "malarial disease" of New York is wrongly so called, since the most striking phenomenon of this affection, its periodicity, is frequently absent. But, while he insists upon the desirability of making a positive diagnosis to that effect only in cases of frank intermittent fever, perhaps he does not lay enough stress upon the peculiar masked forms of the disease which undoubtedly abound among us.

It is a common experience with our surgeons to meet with sudden and unaccountable elevations of temperature after operations, elevations which can not be attributed to the condition of the wound, or to the occurrence of inflammatory complications. This phenomenon is apt to cause no little uneasiness, especially in peritoneal surgery, in which a sudden rise of the index at an early period is well known to presage the invasion of peritonitis. But this occurrence is not confined to major operations, since trifling manipulations of the uterus, such as trachelorrhaphy and curetting, may be followed by fever, which is equally alarming, being suggestive of parametric inflammation. Now, a peculiarity of this rise of temperature (which is often accompanied by a rapid pulse and a good deal of constitutional disturbance) is that it observes a sort of periodicity. In the morning the thermometer will register as usual in uncomplicated surgical cases, while toward evening, on visiting his patient, the attendant will be surprised, and often alarmed, to find a reading of 103° or 104° F. The wound is examined, the patient is interrogated, but, aside from a confession of restlessness and nervousness, nothing can be elicited to explain the fever. There may or may not have been a preceding chill; generally it will not have been recognized. As the patient convalesces, these mysterious symptoms will disappear. With the administration of full doses of quinine, according to the ordinary rules observed

in using this drug for the cure of intermittent fever, the attacks will generally be cut short in two or three days. In most of the cases which have fallen under our observation, either a history of malarial exposure could be obtained, or subsequent observation of the patient after complete recovery from the operation showed that the disease was present.

The interesting point in this question is, what peculiar condition of the system is induced by a surgical operation whereby latent, or masked, malarial disease becomes actively developed? This we do not pretend to answer. It is akin to the sudden appearance of delirium tremens after injuries. The practical interest of the subject lies in the inference that the surgeon should not allow a rise of temperature *per se* to disquiet him—indeed this is only another phase of the question which Nothnagel has lately brought into prominence.—*N. Y. Med. Jour.*

**EXCISION OF THE KNEE IN PREFERENCE TO AMPUTATION IN CERTAIN DEFORMITIES OF THE LEG.**—Dr. Stephen Smith, of New York, read a paper with this title, at the New York State Medical Society meeting, December, 1884. There was a certain class of cases in which the question of excision at the knee, or amputation at or below that point, was to be determined. They were those cases in which the leg was rendered useless for locomotion, closely allied to those cases of deformity and displacement in which there was chronic inflammation, and the weight of the body could not be borne on the limb. The solution of the question would depend upon two points: the comparative safety of the two operations and the comparative usefulness of a stump after an amputation at the knee-joint, and at a point immediately above or below that point. Out of fourteen cases of partial excision, but two patients died, which was a mortality of only two per cent., showing a difference of eight per cent. in favor of excision. In a large collection of cases, amputation below the knee gave a mortality of thirty-four per cent., and amputation above the knee gave a mortality of sixty-three per cent. Although these figures showed that excision was by far the less dangerous, for purposes of comparison he would place them on the same footing. Perhaps the greatest weight of authority on the question had been furnished by the late Dr. Hudson, of this city, who was employed by the Government for several years. Much as he favored artificial limbs, he always regarded an ankylosed knee as more serviceable than a stump to which an artificial limb might be adjusted. In the light of these facts, we might formulate conclusions in regard to these operations as follows: That excision at the knee-joint was quite as safe as amputation above or below that joint; that excision of the knee-joint was to be preferred to amputation, by which the leg was rendered useless.

Dr. S. W. Gross, of Philadelphia, took it that excision of the knee-joint was not the proper operation in all cases of deformity of the knee; for instance, in cases of ossification or synostosis of the joint he saw no necessity of resorting to excision at all. In such cases it had been his practice, and that of his father, the late Professor Samuel D. Gross, to make an incision across the knee, and break up the osseous union with a chisel. Then the patella could be separated from its adhesion to the femur by force applied to it through a towel interposed. Then, on account of the danger of rupturing the popliteal artery, it was not safe to attempt to straighten the limb entirely at once, but it was best to bring the foot down only so far as was necessary to make the toes touch the floor—the heel, he thought, should swing about an inch above the floor. Even this it was safer to accomplish gradually, at several operations, the patient being anesthetized each time. This operation, he thought, should be more widely practiced in preference to excision, as had been taught by the late Professor Gross, in his "Surgery." In regard to the statistics brought forward by the reader of the paper, he would say that they had been materially changed within the last five or six years, and no surgeon who resorted to antiseptic precautions would expect to have a mortality of more than three or four per cent. after amputation of the leg.—*Medical Record.*

**TREPHINING IN MASTOID AND TYMPANIC DISEASE.**—Dr. W. J. Wheeler, of Dublin, at the conclusion of an article on this subject, says:

Of the 35 cases in which the trephine was used, 4 terminated fatally, while the result in the other cases has not been reported; in the total number of cases, the results of which are differently specified, 17 per cent. were fatal, and 21 per cent. successful. Buck has collected 37 cases of suppurative inflammation in which the cases were left to nature (expectant treatment); 34 were fatal. It will be readily seen from the foregoing that the operation of trephining for mastoid disease is a fairly successful one, and, on the other hand, that, from the expectant treatment in suppurative inflammation there is little to look forward to but a fatal result. That the operation should be practiced early is a self-evident fact; it is useless when pyæmia, meningitis, or phlebitis of the sinuses has appeared, although the first cerebral manifestations should not intimidate the surgeon from operating, and I doubt not but that good service will be done toward the patient by his attendant who advises operation even where no bone disease existed, but when the discharge from the tympanum has lasted for a *lengthened period*, and has not yielded to other treatment, such as syringing and enlarging the opening of the membrana tympani if necessary. Setons and issues I believe to be of little use, for

although only the mucous membrane may be engaged, yet we know that a blow on the mastoid process, a severe cold, a depressing illness, may cause disease to advance to the bone, pyæmia may ensue, or death by general cerebral irritation, without the formation of abscess. A well-accomplished operation will always give free vent to pus when existing, and prevent it passing to the brain through some of the numerous channels I have recorded, and will thus save the patient. I must deprecate the operation recommended by Dr. Bagroff—namely, the use of the gouge and galvano-cautery over the mastoid process; such procedure, as it appears to me, would be likely to set up irritation and inflammation. Unless, indeed, the suppuration is comparatively superficial, or discharging through a fistulous opening, I would not select to operate over the mastoid process; there one cannot remove the entire portion of the bone, on account of the proximity of the lateral sinus, and so cannot expose the dura mater, to do which I hold is very essential.

The site I would always select for operation, with the exceptions as above named, would be such as to place the lower border of the trephine on a level with the external auditory meatus, and anterior to a line dividing vertically the mastoid process. By adopting this course there will be no danger of wounding the lateral sinus, the tympanum and mastoid cells will be opened, giving full exit for discharge, the dura mater will be exposed, and should pus exist between it and the cranium, there will be ample freedom for its escape.—*Dublin Journal of Med. Sc.*, October, 1884.

**DISINFECTANTS.**—At the close of a paper on this subject, Dr. W. J. Miller, of Dundee, draws the following conclusions:

"1. It is very doubtful that any efficient disinfection of a room can be practised while it is occupied. Nevertheless, it is possible that the presence of a disinfectant, though not in sufficient concentration to kill contagium, may, by long continuance of operation, weaken it, and, if microzymes be the contagium, may so lower their vitality as to impair their power to reproduce their kind. A certain degree of probability is given to this by Prof. Tyndal's observation of the effect of continuous heating in sterilizing putrescent liquids, which led him to conclude that there is a period in the life-history of these minute organisms when they are especially vulnerable. It is therefore, in the direction of good to employ some disinfectant during the progress of the case, and there is none equal, either in efficiency or in simplicity of application, to sulphur. It is exceedingly convenient in practice to use sulphur pastiles, as introduced by Dr. Littlejohn, each of which contains twenty-five grains of sulphur, one or two being used at a time, according to the size of the room. This should be done several times a day.

"2. The skin of the patient should be sponged several times a day with diluted acetic acid, by preference with the aromatic. This is especially applicable in scarlet fever, effectively disinfecting the desquamating skin. I only mention the method of inunction to condemn it emphatically. The strength of the solution must be regulated by what is found agreeable to the patient; a 1 to 20 solution of the aromatic acid, which has been referred to, is generally too strong.

"3. For the final disinfection of the sick room nothing equals sulphur. But it must be thoroughly applied. The Dundee sanitary authority uses about three pounds of sulphur to a room about ten feet square, carefully closing all apertures by which the fumes can escape, and leaving the room shut up for about four hours.

"4. For disinfection of clothing, etc., the method followed here is exposure to a temperature of about 250° for three hours in a specially constructed chamber, the air being also charged with the fumes of about six pounds of sulphur. It is scarcely possible that any contagium can live through such an ordeal.

"5. Excreta of patients are best dealt with by Dr. Dougal's method—namely, mixture with hydrochloric acid diluted to 1 to 20. He has proved that this solution does not injure the metal fittings with which it comes for so short a time in contact. Clothes may also be thoroughly disinfected by this agent, and without injury.

"6. For hand disinfection, carbolic solutions 1 in 20, acetic acid, and sulphurous acid, are almost certainly thoroughly effective.

"7. The question of disinfectant inhalations for lung disease, especially phthisis, demands a longer consideration than can here be given to it, but, when we consider that vaccine which has been exposed for three hours to air saturated with creasote vapor, and similarly for four hours to the vapor of eucalyptus, retained its infectivity unimpaired, that the germs to be acted on are far in the recesses of the air-vesicles, and that the inhaled disinfectant can only reach them in very weak dilution, if indeed it reaches them at all, it appears to me, although it is very disappointing to arrive at such a conclusion, difficult to place much confidence in this therapeutical expedient."—*Practitioner*, Oct '84.

**THE PAINLESS EXTINCTION OF LIFE.**—The *Med. Press and Circular* states that: Dr. Richardson's lecture on "The Painless Extinction of Life in the Lower Animals," at the Society of Arts last week attracted a very large audience, among whom we noticed many members of the profession. The lecturer prefaced his subject by stating that he had, at the request of the Committee of the Dog's Home, Battersea, constructed a lethal chamber for the painless extinction of the life of dogs which nobody owns, which must of necessity be destroyed.

He put the process into operation in May last by subjecting thirty-eight dogs to the fatal vapor, and all passed rapidly into sleep and from sleep into death. Since then from 200 to 250 dogs per week have been painlessly killed in the chamber. The number struck us as unusually large, and we were almost tempted to ask what the anti-vivisectionists were about, and why they so cruelly abandoned so many of their pets—7,000 in a few months—to starvation or to the tender mercies of the police and the uncertainty of prussic acid. The numbers, however, Dr. Richardson said, had been exceptionally large and the experimental results so entirely practical and successful that he felt the time had come for him to place them fully before the public. The process at first was not unaccompanied with difficulties—first, in determining the anæsthetic to be employed, and next as to the most efficient form of chamber in which the animals should be exposed to the lethal gas or vapor. Out of a list of twenty-two anæsthetics he had selected four of the best known among them, which he subjected to a careful series of trials, and of these he finally selected carbonic oxide as the easiest to deal with and the least expensive. The lethal chamber is filled with gas by an ingeniously constructed Clarke's stove.

As to the painlessness of the death of the dogs, there can be no doubt whatever, and Dr. Richardson firmly believes that the same method might be used for the destruction of those animals which supply us with food. Indeed, he has already tried it with sheep, which are put down to sleep with the greatest rapidity before being slaughtered, and it has been found that the carbonic oxide exercised no prejudicial influence over the flesh of the animals, nor did it unfit it in any way for the market as food.

The same process is found equally applicable to swine, calves and fowls, so that steps have been taken to carry out the lethal process on a large scale. The objection even to retention of blood so strongly felt by the Jewish people do not obtain by the process, as the animals in the sleep of death are found to yield up blood just as freely as in the ordinary way, or when no anæsthetic is used.

Upon the issue of these experiments Dr. Richardson deserves the gratitude of the entire community. Looked at from whatever point, his efforts were praiseworthy, and the results constitute a triumph to science and a boon to the lower creation. If—as he eloquently concluded his lecture—Science sometimes, for the sake of man, inflicts pain on the lower creation, here she relents, and does for the lower creation what she dare not do for man.

**CREDE'S METHOD OF DELIVERY OF THE PLACENTA.**—Dr. W. H. Taylor, in the *Cincinnati Lancet and Clinic*, says: The vigorous controversy over "Crede's method," which has recently involved so many obstetricians, has led Crede to re-

state in detail the manipulation he advises. As many American practitioners habitually adopt what they believe is his practice, I think it will be of interest to know exactly what that method is, I therefore have translated his own description, giving the italics as found in the original, in the *Archiv. für Gynakologie*, xliii, 2, 213:

... "The natural detachment of the placenta occurs within a few minutes after the birth of the child, and is recognized by a discharge of blood and by marked diminution of the size of the uterus, which may now be felt as a firm ball, the size of a child's head, between the umbilicus and pubes. As soon as any after-pains have occurred the midwife grasps the entire uterus through the abdominal walls with both hands and presses it toward the concavity of the sacrum, she repeats this *several times*, if necessary, *but only during a pain*, until the placenta is found at the vulva or is entirely expelled. If, from imperfect contraction of the uterus, or from tenderness of the abdominal walls, sufficient pressure to expel the placenta can not be made, the attendant, guided by the umbilical cord, feels carefully in the vagina for the placenta; if a portion is felt, then, with one hand, *gentle traction* is made on the umbilical cord, while with the other pressure is made over the uterus. If the point of insertion of the cord in the placenta can not be reached, or if on *gentle traction* of the cord resistance is felt, no further effort to deliver the placenta in this way may be made until after *several uterine contractions* have occurred, which may be increased by *gentle rubbing and pressure*. If the placenta is found low in the vagina, and readily reached by the finger, then the attendant shall pass the index and middle fingers as far upon the placenta as possible and press it gently downward and backward, while with the left hand the cord is made tense. When the placenta appears at the vulva the attendant shall grasp it with the fingers of one hand, and draw it gently upward and slowly turn it upon itself several times in order that the membranes may form a cord and not be torn away. When delivered the entire after-birth and any coagula are removed under the flexed leg of the woman and placed in an empty basin.

"*All strong traction* on the umbilical cord, or attempts to extract the placenta when high up by introducing a part or the whole hand, or to aid the efforts at extraction by straining, coughing, blowing in the hands, etc., are *very dangerous* and therefore are *forbidden*."

**HIP-JOINT AMPUTATION.**—DAVY'S LEVER.—The following important cases under the care of Mr. Haward, of St. George's Hospital, London, are reported in the *Lancet* for January 3, 1885:

John D——, aged twenty-four, received in May last a blow on the right buttock from the buffer of



a locomotive. When admitted soon afterwards into St. George's Hospital, the buttock presented near its most prominent part a contused and lacerated wound large enough to admit a finger. Out of the wound dark blood oozed very freely. The soft parts were very extensively undermined, and beneath them was a large and increasing collection of blood. This blood collection did not pulsate and no bruit was audible. A pad was firmly bandaged over the buttock for three hours. In this interval the collection of blood had greatly increased, and when the pad was removed large quantities escaped. Ether was then administered and the right iliac artery compressed with Davy's lever. When once introduced far enough, this instrument acted perfectly. Mr. Haward enlarged the wound to a length of some six inches. The gluteal muscles were found to be torn across, and beneath them existed a large cavity full of blood. This was quickly turned out, bringing into view the sciatic notch and the open mouth of the gluteal artery. This and a great many other muscular vessels were secured with catgut ligatures. No blood was lost during the operation and the man's recovery was uninterrupted.

The case shows well the value of the lever, and in connection with this subject of compression of the large vessels of the abdomen it seems well to mention a case of amputation at the hip-joint for sarcomatous disease, which also occurred in Mr. Haward's practice. Here the abdominal aorta was very effectually controlled by a contrivance more or less like that suggested by Sir Joseph Lister. The blunted apex of a pyramidal piece of wood was fixed over the abdominal aorta by an elastic bandage. The apex of the pyramid was about one inch square and covered with felt. The base measured about three inches square and presented instead of a plane surface a broad and shallow groove. The elastic bandage passed round the pelvis and along this groove. When fixed it was placed in the charge of an assistant, who, grasping the wood with both hands, could very easily and nicely direct and regulate the pressure. This contrivance caused no dyspnoea and completely checked all bleeding.

THE ENGLISH CHOLERA COMMISSION.—Drs. Klein and Gibbes have sent the following report to the Surgeon-General and Sanitary Commissioner of the Government of India. Dated Calcutta. Nov. 27th, 1884—(*Lancet*, Jan. 3.)

We have the honor to report that the investigations which we have hitherto carried on in Bombay and Calcutta have yielded the following results:

1. The statement of Koch that "comma bacilli" are present only in the intestines of persons suffering from or dead of cholera is not in accordance with the facts, since "comma bacilli" occur also in other diseases of the intestines—e. g., epidemic

diarrhoea, dysentery, and intestinal catarrh associated with phthisis.

2. The "comma bacilli" in acute typical cases of cholera are by no means present in such numbers and with such frequency as to justify Koch's statement that "the ileum contains almost a pure cultivation of comma bacilli."

3. The "comma bacilli" are not present in the tissue of the intestines or elsewhere.

4. The "comma bacilli" in artificial cultivations, carried out by one of us (E. K.), do not behave in any way differently from other putrefactive organisms.

5. Mucous flakes of the ileum, taken out soon after death from typical acute cholera, contain numerous mucous corpuscles, many of them filled with peculiar minute straight bacilli. The same bacilli occur also outside the mucous corpuscles. They are never missed even when the "comma bacilli" are.

6. These small bacilli have been cultivated by one of us (E. K.), and they do not behave differently from putrefactive organisms. They are not present in the tissues of the intestine or any other tissue.

7. No bacteria of any kind, and no organisms of known form and character, occur in the blood or any other tissue.

8. A good many experiments have been carried out by one of us (E. K.), with the following results: (a) Mice, rats, cats, and monkeys were fed with rice-water stools, with vomit, with mucous flakes of the ileum, fresh and after having been kept for twenty-four to forty-eight hours. The animals remained normal. (b) Inoculations with recent and old cultivations of "comma bacilli" and the small straight bacilli, as well as with mucous flakes, were made into the subcutaneous tissue, into the peritoneal cavity, into the jugular vein, and into the cavity of the small and large intestine of rabbits, cats, and monkeys; but the animal remained perfectly well and normal.

9. The material which we have had hitherto at our disposal has been very good and abundant, and, as far as the microscopic work goes, we do not think we shall require any more material. We therefore propose concluding our inquiry by the beginning of December, and hope soon after to return to England.

PATHOLOGY OF CYSTITIS.—According to M. Hache (*Revue de Chir.*, No. 4, 1884) lesions of the bladder and irritation applied directly to its wall and mucous membrane do not constitute a necessary and sufficient cause of cystitis, except in case of vesical tuberculosis, or of the presence of a rough and irregular shaped foreign body. The causes capable by themselves of constantly determining inflammation of the bladder are very rare. Beyond tubercular cystitis, and other forms of cystitis due to some general morbid condition—as.



for instance, those of rheumatic, gouty, and infective nature, which are not of frequent occurrence—there cannot be included in the above category scarcely any save severe accidental or surgical traumatism of the bladder, and too sudden and complete evacuation of this organ after over-distension. Gonorrhœal urethritis does not often give rise to cystitis, except under the influence of some occasional cause or in a predisposed subject. Most of the predisposing causes act quite simply by determining a more or less persistent congestion of the bladder; others have a more or less obscure mode of action, although their influence is very decided. Chief amongst these predisposing causes are the tubercular, rheumatic, and gouty diatheses. These predisposing causes may sometimes become exciting causes by increase, extension, or repetition of their action, or through association with that of other causes of the same group. These latter causes are congestion and slight inflammation of neighboring organs, especially in the female; tumors, calculi, and foreign bodies in the bladder; incomplete retention of urine, with or without distension; habitual resistance to the needs of micturating, and all the causes of dysuria and functional over-activity of the bladder; stricture and foreign bodies in the urethra, hypertrophy of the prostate, etc. Finally, the part of exciting cause is more especially played by sudden and complete retention, by cold, by catheterism or exploration of the bladder. The latter cause can act only on a bladder predisposed by the presence of a tumor or calculus; the other two causes are more active, and may even by themselves suffice to excite an attack of cystitis. M. Hache's study of the pathogeny of cystitis has led him to insist on the importance of congestion and diathetic influences, especially the tubercular diathesis, and on the relatively limited part played by lesions of the urethra and prostate.—*London Med. Record*.

**TREATMENT OF ABSCESS OF THE LIVER.**—A few years ago M. Jules Rochard reported to the Académie de Médecine a method of healing abscesses of the liver by large and direct opening, combined with the Listerian antiseptic method. This operation consists, when the abscess is only suspected, without being diagnosticated, in using the needle of an aspirator. Then if pus be found, the needle is used as a director along which a bistoury is carried, and the abscess is opened. The cavity is then injected with antiseptic solutions, and drained. About the same time, Surgeon Major Oberlin, of the French Army, had occasion to treat several cases of abscess of the liver. He gives the history of three cases. The first case was aspirated with Potain's aspirator, a large amount of chocolate-colored pus drawn off, and the patient recovered.

The second case was that of a woman, thirty-six

years of age, about 15xviii of chocolate-colored pus were drawn off with Potain's aspirator. The patient then had an attack of intermittent fever, and the abscess partially refilled. A little more than 13vj of pus were removed. About six weeks afterwards a third aspiration removed about 13vii of pus. The fever continued, however, the patient got no better, and the abscess refilled. One week after the third aspiration the abscess was opened with a large trocar, the pus removed, and a caoutchouc tube introduced. A 1 to 40 solution of carbolic acid was then thrown into the cavity, and a Lister dressing applied after the injection had ceased to return clouded. The dressings were repeated daily for five days, when the first tube was replaced by a short one. The wound was completely cicatrized in a month.

M. Oberlin believes that in using the aspirator it is well to make several punctures at intervals. He also states, what is not new, but worthy of further attention, that abscesses of the convexity of the liver cause pain in the right shoulder; but this is absent in cases of abscess of the left lobe or base.—*Archive. de Méd. et Pharm. Mil.*, Oct. 1, 1884.

**VOLUMINOUS ENEMATA OF NITRATE OF SILVER IN CHRONIC DYSENTERY.**—Dr. Stephen Mackenzie read a paper on this subject before the Clinical Society of London (*Med. Times*). The mode of procedure he adopted was as follows: The quantity of nitrate of silver to be used was dissolved in three pints of tepid water in a Leiter's irrigating funnel, which was connected by India-rubber tubing with an œsophageal tube with lateral openings. The patient was brought to the edge of the bed and made to lie on his left side, with his hips well raised by a hard pillow. The terminal tube, well oiled, was passed about eight or ten inches into the rectum, and the fluid allowed to force its way into the bowel by gravitation. The injection rarely caused much pain, and often none. It usually promptly returned, but when long retained it was advisable to inject chloride of sodium, to prevent absorption of the silver salt. Various strengths had been used, from thirty to ninety grains to three pints of water, but usually one drachm of nitrate of silver was employed. The treatment was based on the view that, whatever the nature of dysentery, whether constitutional or local, in the first instance, the later effects were due to inflammation or ulceration of the colon, which was most effectually treated, as similar conditions elsewhere, by topical measures. Sometimes one, sometimes two injections were required, and in some cases numerous injections were necessary; but in all cases thus treated, many of which had been unsuccessfully treated in other ways previously, the disease had been cured. The cases narrated were: 1. In which the disease had lasted several years on and off; two injections were used and the case was cured in six weeks.

2. Second attack, duration uncertain; four injections used; cured in five weeks. 3. Duration two months; two injections used; cured in three and a half weeks. 4. Duration five years; one injection used; cured in three weeks. 5. Duration eighteen months; two injections used; cured of dysenteric symptoms, but remaining under treatment for diabetes. 6. Duration fourteen months; one injection used; cured in seven weeks.

Dr. Carrington said that this treatment had been tried in the hospital at Greenwich without any remarkable effect, but the injections had not been so voluminous as those used by Dr. Mackenzie, which might, perhaps, explain the fact. The colon was usually capable of holding six pints of fluid, and the three pints used in some of the cases might possibly have failed to reach the affected parts.

**REMOVAL OF GALL STONES.**—The Dublin *Medical Press and Circular* of October 1, 1884, says:—The current number of the *Independence Belge* mentions a surgical operation which has just been performed in Brussels by Dr. Langenbusch of Berlin, who must not, however be confounded with his eminent fellow-citizen Langenbeck. The subject of this daring and successful proceeding was M. Eugene Anspach, the Deputy Governor of the National Bank of Belgium, who has been for many years suffering from a collection of gall stones, which have kept him in a state of aggravated suffering (*doleur atroche*) and have latterly defied all measures of relief. M. Langenbusch, summoned specially from Berlin, proposed to lay open the gall bladder, with antiseptic precautions, admitting, however, that he had only performed this operation four times, and that but one of these cases had recovered. M. Anspach's family and friends were much dismayed at this announcement, and begged that the operation should not be performed. M. Anspach was firm, and reflecting that without it he would not live long, and that in the meantime his life would be worse than death, decided on the operation. Even in this supreme moment the banking mind asserted itself, and M. Anspach remarked "after all, one in four is 25 per cent., and that is a fine dividend." "You have had one recovery already, doctor," he remarked, "and I will be the second," an element of confidence which no doubt had something to say in the result. The operation was performed on the 9th September, and 125 calculi were extracted from the gall bladder. M. Anspach suffered a good deal after the proceedings, but is now out of danger and in complete comfort. We trust he will long live to enjoy the reward of his own pluck and the skill of his surgeon. It is a curious circumstance that this operation has to a certain extent been anticipated here. The late Sir Timothy O'Brien suffered from gall stones, and the late Sir Dominic Corrigan worked down into the gall bladder by means of a

potash issue, and removed them. Sir T. O'Brien's recovery was complete.

**TREATMENT OF CHRONIC HYDROCEPHALUS BY TAPPING.**—Dr. J. G. Palmer M.D., of Oakbowery, Ala. reports in the *N. Y. Med. Record* a case of successful treatment of congenital hydrocephalus. The patient was a negro baby, seven months old. He was called to see the child in July last. He diagnosed the case as one of congenital hydrocephalus, and told the parents that the only hope for cure was in tapping. To this they would not consent. The accumulation continued until the head reached the enormous size of twenty-six inches in circumference—the bones of the head having become very thin by reason of the pressure within. There was a space of two inches between the bones. The eyes were turned up under the upper lids from pressure upon the brain. In consultation with Drs. Garison and Spratling the importance of tapping was urged and the parents consented. A small hydrocele trocar was inserted at the posterior portion of the anterior fontanelle, the head having first been shaved at the place of insertion of the trocar. The fluid flowed freely. About eight ounces were drawn off, the trocar withdrawn, and a piece of absorbent cotton placed over the place of puncture, and held in place by a piece of adhesive plaster. The bones of the head were pressed into position, and held in place by a tightly fitting bandage. Next day bandage, plaster and cotton were removed, and more fluid was allowed to drain off, though much had done so during the night by the plaster coming off and the cotton being moved out of position. The fluid was allowed to drain off at intervals until all was removed. The child was then put upon iodide of potash, which was kept up for several weeks. The eyes soon regained their normal position. The child nursed well and fattened rapidly. There were some febrile symptoms for several days after the operation, but they soon subsided. The head is yet big from the large size of the bones, as they were very thin. The bones seem to be rapidly uniting, and the child is still fattening and growing.

**INCONTINENCE OF URINE IN CHILDREN.**—In his recent work on diseases of children, Dr. Eustace Smith gives the following:

Of medicines which diminish irritability, belladonna takes the first place; but it is important to be aware that this remedy, to be effectual, must be given in full doses. Children have a very remarkable tolerance for belladonna, and will often take it in surprising quantities before any of the physiological effects of the drug can be produced. In obstinate cases of enuresis the medicine should be pushed so as to produce dilatation of the pupils with slight dryness of the throat. In children of four or five years of age, it is best to begin

with twenty-five or thirty drops of the tincture of belladonna, given three times in the day, and to increase the dose by five drops every second or third day, of course watching the effect. Ergot is another remedy which is often very successful. For a child of the same age twenty drops of the fluid extract may be given several times in the day.

Bromide of potassium, benzoic acid (dose, five to ten grains) and benzoate of ammonia, digitalis, borax, cantharides, camphor, and chloral have all been recommended as specifics in this complaint. Sometimes a combination of several drugs seems to be more effectual than one given alone. I have lately cured a little girl, aged four years, who had resisted all other treatment, with the following draught given three times in the day :

R Tinct. Belladon. . . . . ʒ j.  
Potass. brom. . . . . grs. x.  
Infus. digitalis. . . . . ʒ ij.  
Aquam ad. . . . . ʒ ss. M.  
Ft. haustus.

When the incontinence continues in the day as well as at night, strychnia should be combined with the sedative so as to give tone to the feeble sphincter. In these cases, too, cauterization of the neck of the bladder, with a strong solution of the nitrate of silver (ʒ j. ʒ j. to the ounce of water), has been found successful.

**APPARATUS FOR CHRONIC JOINT DISEASE.**—**BARWELL**—Mr. B. in a clinical lecture now gives the preference over Taylor's, Sayre's, and Thomas', to the following apparatus for chronic joint diseases, the apparatus being modified for different joints. The method is one to which his attention was called by Dr. Von Wahl, Dorpat, but invented by Dr. Dumbrowski of that University. The knee-joint is taken as an example. To the knee above and below the joint poroplastic felt or leather is moulded by the hand or by bandage; while these are hardening the sound limb is placed with its posterior aspect on a piece of paper and a tracing is made of its inner and outer aspects. The circumference of the top of the thigh is taken in an oblique direction, *i. e.*, from the perineum to a point a little above the great trochanter. The splint-like moulds being removed, the instrument-maker bends two flat bars of steel or of iron, about three-fourths of an inch broad, to the shape of the tracings, only with a larger divergence at the knee and two to two and a half inches longer than the limb. These bars are to be rivited to the poroplastic felt or leather, which is provided with straps. The upper ends of the bars are made fast to a well padded ischio-iliac ring, provided in front with a hinge and flap. The lower ends are fastened by a pivot joint to a plate that underlies the sole. To put the appliance on, the leather or felt is to be

softened, the ischio-iliac ring opened; the limb being put in, the straps are buckled and the patient left at rest until the leather or felt has hardened. A high-heeled shoe is made for the sound foot and the patient allowed to go about; at first on crutches, afterwards without them. Motion can not take place at the joint, nor can the weight of the body fall upon it. The joint is at perfect rest and can be examined.—*Lancet*.

**THE TREATMENT OF GASTRODYNIA.**—The following instructive case is reported by Dr. John W. Martin, in the *Medical Press*.

Miss R., æt. 30, came under my care, October 3, 1884, suffering from pain in the stomach after meals, and the consequent dread of and loss of desire for food. When seen she looked quite worn and thin; complexion sallow; lips and gums anæmic; tongue whitish and lightly furred; bowels constipated. She felt a daily-increasing sense of weakness and inability to attend to her duties. Physical examination yielded negative results as regards the condition of the various organs. The case seemed one of dyspepsia consequent upon anæmia. The uterine functions were, with the exception of paleness of the menstrual discharge, normal.

I at first ordered bismuth, soda, and tr. nux vom. mixture with chloroform water; and calomel, colocynth, hyoscyamus pills to regulate the bowels. This giving no relief, I changed to pills of reduced iron and extract of nux vomica with meals, and as a laxative a mixture of sulph. mag. and mag carb., with peppermint water. Again no relief being experienced, I placed her upon the following prescription :

R. Sodæ bicarb., ʒ iss.  
Tr. nucis vom., ℥xl.  
Liq. morph., ʒj.  
Sp. am. aromat., ʒ iss.  
Syrupi zingib., ʒj.  
Aquæ menth. pip. ad., ʒviiij.  
M. ʒj. to be taken four times a day.

The relief was immediate, and so far has proved permanent. Pain is now rarely felt, and only after indiscretions as to food. Relish for her meals has returned. She is now taking the reduced iron and extract of nux vomica pills with meals, and finds decided benefit from them. The bowels are regular, the tongue clean, and her complexion and general appearance much improved.

I am inclined to think the small dose of opiate was just the one thing wanting in my previous treatment, to help the lame dog over the stile.

**THE TREATMENT OF RINGWORM.**—Dr. Smith, F.R.C.S., London, *Brit. Med. Journal*, says :—I have been trying for some time to find out what vehicle penetrates most deeply into the hair-follicles, and think it is chloroform. Chrysophanic

acid is a very good parasiticide; and, though it is insoluble in spirit and ether, yet it is soluble in chloroform. Chloroform also dissolves the fatty matter out of the hair-follicles, and thus allows the parasiticide dissolved in it to penetrate deeply. During the last year I have used a solution of seven grains of the acid to the ounce of chloroform to all cases of recent ringworm, and believe it is the most efficient treatment I have yet tried.

The small patches should be carefully marked out by cutting the hair very closely on them, and the chloroform solution should be well pressed and dabbed into the places with a minute sponge mop for five minutes, two or three times a day, according to the amount of irritation produced. The aim of the treatment is not to produce scabs, but to get the solution to penetrate deeply. The sponge mop should not be much larger than a big pea, and should be continually dipped into the chloroform-bottle, as the solution soon evaporates while it is pressed into the diseased spot, and leaves the yellow acid dry on the place. Great care must be taken that the solution does not run on to the forehead or into the eyes, and that the person using it does not inhale the vapor. I always give full directions about the care necessary in using such a potent remedy, and only apply it to small places of the disease. It is well for the nurse to keep her face away from the sponge, and to use the chloroform in a current of air, and not in a small room. The places should be well washed every morning with hot water and soap, to remove any sebaceous matter or crusts, and the hair should be kept closely cut on them till new hair appears, which is generally in about two or three months; but the remedy should be continued till all diseased stumps have come out.

**STRICT ANTISEPTIC SURGERY.**—An interesting account as to how our German colleagues follow out the antiseptic treatment in operations and the dressing of wounds is found in the *Medical Press and Circular*. Before every operation the steam spray of corrosive sublimate is worked for some time to disinfect the atmosphere of the room. The floor of the operating-room is flooded with water, so that the assistants are compelled to wear rubber boots. During the operation a continuous stream of a solution of sublimate, 1-1000, is directed on the wound. In the dressing of the wound after the edges have been united, a layer of glass wool saturated with a ten-per-cent solution of sublimate is placed over it, over this small pillows of peat dipped in sublimate solution are placed, and over all this sublimated gauze. The dressings are never removed until the wound heals or some discharge shows through the dressings. The results gained by Schede, of Hamburg, in this manner are astonishing. Out of an immense number of operations performed in 1883, among which were nine

cases of resection of the hip-joint, there were only two or three cases that showed any sign whatever of suppuration.—*Louisville Med. News*.

**CHARCOT'S JOINT DISEASE.**—A very important discussion of this subject has recently occurred at the London Clinical Society. The names of the prominent men who participated in the debate are a sufficient assurance that the question was illuminated with the light of the best minds of the profession. The general tendency of the meeting was to consider the affection not as a distinct disease, but rather as a form of chronic rheumatic arthritis occurring in patients with locomotor ataxia. There was a disposition on the part of the surgeons present to regard the nervous theory of its production as rather an imaginative way of explaining a gross surgical condition. Professor Charcot was invited to be present at the discussion but was unable to attend.—*N. Y. Med. Journal*.

**NITRO-GLYCERINE IN MITRAL LESIONS.**—At the clinic, (*Col. and Clin. Record*) Prof. Bartholow gave nitro-glycerine to a patient with a mitral lesion causing pulmonic and renal congestion, albumenuria and general œdema. He thinks it the best thing we have for congestion of the kidneys, and valuable to take work off the heart, by lowering the tension. It does not interfere with nutrition, like digitalis. One drop of a one per cent. solution, slowly increased to flushing of the face, is the dose.

**OBSTINATE CONSTIPATION.**—The *Col. and Clin. Record* states that a woman presented herself at the clinic complaining of constipation consequent upon atony of the lower bowel. Often she had been six weeks without a passage, and at no time during the last year had she an evacuation under two weeks. Prof. DaCosta placed her upon the following treatment:

R	Magnes. sulph.,	ʒij	
	Acid. sulph. dil.,	fʒij	
	Ferri sulph.,	ʒj	
	Aquæ,	Oij.	M.

SIG.—A wineglassful ter die.

She was also given strychninæ sulph., gr.  $\frac{1}{60}$ , at meal times.

**PASTE FOR COMEDONES.**—Dr. A. Van Harlingen recommended at the last meeting of the American Dermatological Association the following formula for a paste for the removal of comedones (acne); it was first suggested by Unna: Glycerine, 3 parts; vinegar, 2 parts; kaolin, 4 parts.

The partnership heretofore existing under the firm name of Henry C. Lea's Son and Co., Publishers, has dissolved by limitation, and the business will be continued by Charles M. Lea, Christian C. Fenger, Arthur H. Lea and H. M. Barnes, under the name of Lea Brothers & Co.

# THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science  
Criticism and News.

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREKT & Co., 30 Cornhill, London, Eng.; M. H. MAILLER, 23 Rue Richer, Paris.

TORONTO, FEBRUARY, 1885.

*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## THE TREATMENT OF WOUNDS.

When we consider how slight a wound may cause death, the importance of the subject which heads this article becomes at once apparent. If to this be added the great frequency of wounds, we have another cogent reason for regarding the subject as one of the first importance to every surgeon. Even in this Dominion it may safely be asserted that not a minute passes but some surgeon is at work on a wound, either accidental or surgical. It cannot therefore be wondered at that much has been said and written on the treatment of wounds, or that the subject has engaged the earnest attention of the best minds in the profession all along the line of surgical progress. Since the advent of the use of antiseptics, union by first intention has to such an extent become the rule, that any surgeon valuing his reputation is expected to offer some apology in case of failure. This certainly is a wonderful advance, and implies more, in the saving of time, pain and life, than we can have any conception of. Yet there is too much reason for the belief that, outside the great centres of population, the methods by which these humane ends are reached are comparatively neglected, and that still the old method of ligature, adhesive straps, and water dressing is in vogue. True, carbolic acid is used, and more attention is paid to cleanliness; still, in the main, modern improvements do not prevail to the extent that many imagine. The chief cause of this is not far to

seek. The antiseptic treatment of wounds, as practised by Lister and his followers, is too elaborate and complicated to commend itself to those who are but seldom called upon to treat any but trivial wounds, which, as a rule, do very well under a more simple treatment. This fact without doubt has been a source of discouragement, and has engendered a spirit of apathy, not to say antipathy, towards antiseptic treatment, as well as other improvements. Now, however, that Listerism in its entirety has been shown to be very little, if any, superior to a modification of it, so simple and inexpensive as to be within the reach and capacity of all, there can be no longer any excuse for holding to practices long since condemned by those best qualified to speak.

Comparatively few surgeons operate under the carbolic spray. Most of them deem it sufficient to observe the most scrupulous cleanliness, combined with careful disinfection of hands, instruments, etc., with carbolic acid or corrosive sublimate in solution. All wounds should be thoroughly sponged with a disinfectant before being closed. Mr. Bryant, the celebrated operator at Guys' Hospital, recommends sponging the raw surfaces with hot water, impregnated with sufficient tinc. iodine to give it the color of sherry. This is the antiseptic used by Mr. Garrard of Sheffield, and other well-known surgeons. This method is considered by many superior to the spray, since the heat has the power of sealing up the minute vessels by coagulation. This solution is also a valuable styptic in all operations where there is oozing from a great number of small vessels. The introduction of the cat-gut ligature, which is cut short and eventually absorbed, is a great advance in surgery, and should be employed wherever it can be relied upon. This is Lister's method of securing arteries. Bryant, on the other hand, uses torsion only, even in the case of large arteries. In writing to the *Lancet*, as far back as 1874, after six years' experience of twisting, he tells that in a case of amputation of the forearm where all bleeding was arrested by torsion, except the interosseous artery, which he ligatured with gut, secondary hemorrhage occurred on the sixth day; the flaps were opened, when the bleeding was seen to come from the vessel that had been tied. He adds: "This is the only case of secondary hemorrhage from a stump which has occurred to me since I began

the practice of torsion in 1868, and it is interesting to know that it came from an artery that had been ligatured, and that the ligature was carbolized gut. . . . We have now had at Guy's Hospital 200 cases of thigh, leg, arm and forearm amputations, in which all arteries have been twisted, 110 of these have been of the femoral artery, and no case of secondary hemorrhage." It is important to add that torsion still holds out at Guy's for all vessels up to the femoral. The vessel to be secured should be separated from its sheath, and "twisted till resistance is no longer felt." It is needless to add that torsion is practised by other eminent surgeons in all countries to the exclusion of the ligature.

The next important point is accurate coaptation of the edges of the wound. Without this, healing by first intention is impossible, no matter how well other details have been carried out. In amputations, especially, it is necessary to exercise deliberation in constructing the flaps, otherwise proper coaptation may be impossible. The wound being closed, it is covered with an elastic pad of absorbent cotton, which has been impregnated with some disinfectant, and secured by the light pressure of a bandage. A drainage tube should be inserted at the lowest angle, if suppuration is deemed inevitable from the nature of the case. A wound thus treated is almost certain to do well. The main points to be careful about are: cleanliness, disinfection, arrest of hemorrhage, accurate coaptation, and, finally, a light, *dry* dressing. All surgeons insist on the wound being kept dry, for the evident reason that moisture and heat are essential elements in decomposition. A wound properly dressed should not be disturbed for four days, unless absolutely necessary. Needless and meddlesome interference only serves to retard the healing process.

The admirable results obtained by this mode of treatment, or some modification of it, have in no small degree stimulated and emboldened the surgeons of the present day, and led them to exercise a freedom with joints, the abdomen, and the different organs, never before ventured, and that, too, with the most surprising success. While it belongs to the few to go to these astounding depths and heights, it is the duty and privilege of all who use the scalpel at all to avail themselves of approved methods, even if it be but to close a wound already made or amputate a finger.

## POPULAR GULLIBILITY.

It would be natural to suppose that in this age of what is called the universal spread of knowledge, the public generally would be comparatively free from the possibility of being taken in by the ignorant charlatan. Such is, however, unfortunately by no means the case. On the contrary, this very spread of knowledge, by giving rise to new and sensational theories, seems to have a peculiar tendency to mystify and mislead.

We have been lately particularly impressed with this by recent popular expositions of the so-called science of phrenology. Phrenology, every intelligent person knows very well, if it step beyond its legitimate sphere, viz., the observation of the general configuration of the skull, and attempts to dogmatize from supposed protuberances—popularly known as bumps—is simply an absurd hoax. Yet we find persons who go about the country and earn a magnificent livelihood by publicly giving utterance to the most palpable falsehoods concerning these said bumps, and actually asserting that they are able, from them, to read character. For ourselves we see no difference between such men and the common fortune-telling gypsy. Nevertheless, it is impossible to take them to task; if the public are willing to pay their fifty cents to hear how "manhood is analysed and restored;" and five dollars to hear what line of life they should adopt, and what sort of wives and husbands they should marry, we are powerless to blame those who cater to such deplorable ignorance.

Yet there is a remedy. To us, as medical men, this is of no little import. Phrenology, as taught by the class of men to whom we have alluded, is closely allied to branches of learning which come under our special protection. It is our duty to discover means by which to eradicate, or even to make impossible, the spread of these erroneous opinions. There are various ways of doing this. But we must follow the example of these persons to this extent: our exposition of these degraded sciences must be made fully as interesting as theirs. And it is quite possible to do so—indeed, in the hands of a skilful lecturer the charlatan could be held up to merciless and ludicrous criticism. We are glad to see that the press has treated this subject properly. Let us not be behindhand in doing our best to trample down scientific falsehoods of every description.

## TREATMENT OF SYPHILITIC LESIONS.

Dr. Seguin published an article in the October number of the "Archives of Medicine," on the use of iodide of potassium in large doses for the relief of the later lesions of syphilis, particularly of the nervous system. He dwells at length on the authorities regarding the dosage of the iodides. Dr. Seguin states—and states correctly, too—that text-books are generally silent on the use of iodides in extremely large doses. He also claims that the practice originated in America. Dr. William H. Van Buren was the first to give potassium iodide in very large doses, and as the results of experience showed its advantage it has been used by others in the same way. Drs. William H. Draper, R. W. Taylor, W. A. Hammond, and others have taught the use of iodide of potassium in large doses for many years, but as a rule it has not been so used until within a short time. All cases of syphilis do not require very heroic treatment. When there is no immediate danger, doses of from twenty to thirty grains three times a day may be given to commence with. In the meantime the effects can be watched, as a few individuals cannot tolerate large doses. In syphilitic manifestations of the nervous system, such as convulsions, hemiplegia, coma, etc., it should be given in the very largest doses at once. Dr. Seguin recommends it in such cases in doses varying from two-and-a-half to ten drachms in twenty-four hours; he gives it before meals, largely diluted. We are pleased with the forcible manner in which Dr. Seguin has drawn attention to this important matter of treating syphilis in the tertiary stage. We have had considerable experience with iodide of potassium in the treatment of syphilis, and have given large doses of the iodides, but have never pushed the remedy to the extent that Dr. Seguin advises. We have usually administered it after meals and not before, as advised by Dr. Seguin. We have never produced iodism to any extent, nor have we observed any gastro-intestinal irritation. In some cases the addition of small doses of mercury may be made with advantage in the treatment.

### AN ENQUIRY COLUMN.

It may not be generally known that there is published in England a magazine called *Notes and*

*Queries*, a very large portion of which is devoted to questions sent in letter-form from subscribers and others on literary, historical, archæological, and other subjects, which are answered in the same form by other readers.

The London *Lancet* has for many years devoted several pages of small print to notes, short comments, and answers to correspondents. This space has been well patronized, which is the best evidence we could have of its value to the profession. Medicine above all other sciences is benefited by the free communication and interchange of ideas among its votaries, and the medical press could thus greatly advance the interests and increase the sum total of knowledge amongst the large body of medical practitioners and students. Apart from the questions discussed by medical societies, and apart from the subjects treated of in papers contributed to medical journals, there are continually cropping up isolated problems which, although in reality often of vast importance, yet cannot be brought within the scope of either of the methods above mentioned. These could be laid open for the consideration and judgment of the profession at large by such a plan as we have referred to, and which it is our intention to adopt. To the student of medicine and junior practitioner it would be a great boon. The junior members of the profession are constantly meeting with difficulties which they cannot solve. Yet many of these difficulties could be tersely discussed through the press by such members of the profession as have the time and the opportunities to devote themselves to lending their aid in increasing the knowledge of medicine besides attending to their regular professional duties. Diagnosis and treatment are not the sole end of the life of a medical practitioner, and this system of notes and queries would tend to extricate many of our medical men from the monotonous groove into which too many of them have fallen.

We invite readers to send us for our March issue a few queries, worded as briefly as possible, on which we shall hope to obtain comments and answers for the succeeding number.

### PROFFSSIONAL ADVERTISING.

Those of our readers who are not in the habit of perusing English papers will be startled to hear



that the supposedly immaculate British physician has betaken himself to advertising. How hath the mighty fallen! Yet so it is. In the London *Times* of December 19th an "F.R.S." sets the ball rolling by describing how "Dr. Hughes Bennett, under whose care the patient was, guided by Ferrier's experiments, skilfully interpreted the palsies and convulsive movements which the man exhibited, and deduced from them that a small tumor was lodged at one particular point in his 'dome of thought,' and was silently and relentlessly eating its way into surrounding tissues, . . . Very brilliant diagnosis this." He goes on to tell in the same graphic and dramatic way how "Dr. Godlee, surgeon to University College Hospital," excised the said tumor.

This sets the whole profession agog apparently, for in a few days the editor of the *Times* is inundated with letters. Dr. "Charles Egerton Jennings, M.S., M.B., F.R.C.S., Eng.," tells how the Vivisection Act "has delayed his own experiments on two subjects, both of considerable importance as tending to save human life when in urgent peril," and proceeds to inform the public that "in 1883 he devised a plan" by which transfusion of blood could be performed without danger. "John H. Clarke, M.D.," also rushes into a criticism of "F.R.S." And so it goes on; and all this hung on the slender peg of a revival of the agitation against the obstacles to vivisection.

We on this side of the Atlantic cannot pretend to be without sin, in view of the highly sensational items that appear in our local papers from time to time, an even quite recently, yet if this goes much further we may feel sufficiently stainless to cast a stone or two.

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**MEDICAL STUDENTS ANNUAL DINNER.**—The medical students of McGill Medical College, Montreal, held their annual dinner on the 4th of December. The members of the Faculty, University officials and a large number of distinguished guests were present. Delegates were also present from the medical schools of Toronto, Kingston, and Montreal. The speeches were appropriate and eloquent, the programme excellent, and the entertainment most successful.

The annual dinner of the medical students of the Kingston Medical College was held on the

11th of December, and was a most successful gathering. Representatives were present from the medical schools in Toronto and Montreal, besides a large number of graduates and friends of the college.

The second annual dinner of the students of the Medical College in Winnipeg, Man., was held on the 19th of December, and was a great success. Speech, song and sentiment were the order of the evening, and a very pleasant time was spent by all.

**TREATMENT OF TUBERCULOSIS.**—Our foreign exchanges have had a good deal to say recently regarding the treatment of phthisis. R. Shingleton Smith, M.D., London (*Brit. Med. Journal*), read a paper at the meeting of the International Medical Congress at Copenhagen, in which he strongly advocated the use of iodoform in tuberculosis. He commences with small doses—one to two grains every four or five hours—and gradually increases the quantity till four to six grains and even more are given.

**PELLETIERINE IN TAPE WORM.**—Dr. Wilfert of Cincinnati, has been experimenting with pelletierine in the treatment of tape worm, and reports the result in the *Lancet and Clinic*, Dec. 27th. This remedy is an alkaloid obtained from pomegranate. The dose is from four to fifteen grains, and should be combined with an ounce of tincture of jalap, or the latter administered a short time afterwards. The results in Dr. Wilfert's practice have been most encouraging.

**GASTROTOMY FOR EXTRA-UTERINE PREGNANCY.**—In the *LANCET* for January 3rd, 1885, will be found a report of two cases of gastrotomy for extra-uterine pregnancy by Dr. James Braithwaite, of Leeds. Both patients recovered. In each case the placenta was apparently attached to the abdominal walls, and was left to slough off and escape through the lower part of the abdominal incision. This was accomplished in about three weeks.

**MALTINE LABORATORY BURNED DOWN.**—The laboratory of the well known firm of Reed & Carnrick was recently completely destroyed by fire, involving a heavy loss to the owners. New buildings have been secured, and the machinery for the manufacture of maltine is being rapidly put up, so that they will soon be able to fill orders for their specialties as usual. Peptonized cod-liver oil and

milk, one of their later specialties, though not long before the profession, already occupies a prominent place among preparations of its kind. It contains 52 per cent. pure oil, and being peptonized in combination with the milk is easily assimilated. It is very palatable; the taste of the oil is well disguised, and it agrees, as a rule, with the most delicate stomach.

**COCAINE IN LITHOTRITY AND RECTAL SURGERY.**—An operation for rapid lithotripsy was recently performed at St. Peter's Hospital, London, (*Lancet*) under muriate of cocaine, with perfect success, and entirely free from pain. The bladder was injected with half an ounce of a 4 per cent. solution of cocaine. Bettelheim, of Vienna, reports a case of enlargement of the prostate in a patient 74 years of age who complained much of rectal and vesical tenesmus. A suppository of cocoa butter containing half a grain of cocaine was introduced into the rectum at bed-time, and relief was obtained during the night and the following day. This was repeated when required and always afforded relief. This remedy is also used in the London Hospitals in the treatment of piles, fissure and fistula with excellent results.

**ONTARIO MEDICAL COUNCIL.**—We observe that some anonymous scribbler has written two or three letters to the Toronto press advocating the doing away with the Medical Council. It is not our custom to notice the effusions of anonymous contributors, and we shall not depart from a well established rule in this case, further than to say that we trust no member of the profession in Ontario will allow himself to be influenced by such erratic nonsense as appeared over the signature of M.C.P.S.O. The profession of Ontario will be very foolish if it ever allow the management of its own affairs to be handed over to the senate of any University however powerful or popular it may be for the time being. There is no prospect of more than a *quasi* or partial federation of the colleges at best, and even if it were an accomplished fact in the fullest sense, that is no reason why the profession of Ontario should, of its own action, yield up any of its privileges or delegate its most important functions to a non-professional body. We will never consent to that.

**NEW REMEDY FOR CANCER.**—Another new re-

medy for cancer has been recently investigated. It is a Brazilian plant named *alvêlos* belonging to the euphorbiacæ. It has been used in the hospitals in Brazil, it is said, with success in several cases. From the reports which so far have reached us, however, it appears to be of value only in the treatment of epithelioma.

**MONTREAL CARNIVAL.**—One of the most noticeable features of the Montreal Winter Carnival is the magnificent special "Carnival Numbers," issued by Montreal publishers. Messrs. Dougall & Son, of the Montreal *Witness*, have issued an excellent number, teeming with illustrations, and having a gigantic four-page picture—"Storming of the Ice Castle by Night"—designed by Mr. R. Harris, A.R.C.A. Besides this there are full page pictures by Messrs. Bird, Raphael, Walker, and other Canadian artists, and the number also contains the Carnival Poem, appropriately illustrated, for which a prize of \$100 has been paid, and a special Supplement representing the various athletic clubs and their leading men. The letterpress pages have been tastefully prepared, and contain a very large number of engravings, representing various phases of our Canadian winter sports. The price is ten cents per copy, postpaid.

**EXCISION OF A TUMOR OF THE BRAIN.**—The sequel of the case of excision of brain tumor reported in our last number has unfortunately terminated in the death of the patient. Hernia cerebri supervened, but the cause of death was meningitis which extended to the base of the brain. The brain was otherwise practically normal.

**APPOINTMENTS.**—Dr. H. V. Ogden (McGill), has been appointed Prof. of Materia Medica in the Milwaukee Medical College, Wisconsin.

The following gentlemen have been appointed commissioners under the Liquor License Act: Drs. J. S. Sprague, of Stirling, and J. S. Loomis, of Madoc, Ont., for the Co. Hastings; Dr. A. Rockwell, for Hastings, W., and Dr. A. McLean, for Lambton, W.,

**ARSENIC IN TUBERCULOUS DISEASE OF JOINTS.**—Arsenic in the form of Fowler's solution is highly recommended for tuberculous disease of the joints, especially when the disease is of long standing and the patient debilitated by suppuration. It is given in combination with cod-liver oil.

**REMOVAL.**—S. F. Wilson, M. A., M. D., C. M. (McGill), has removed from Berwick to Sussex, where he has become associated in partnership with Hon. Dr. Vail. Dr. Wilson leaves a host of friends at Berwick to regret his departure from their midst.

Dr. Darling, Prof. of Anatomy in the University of New York, died on the 25th of December, '84, at the advanced age of 82 years.

The death of Dr. Mahomed, at the early age of 35 years, is announced in our British exchanges.

Prof. Jaeger, of Vienna, the celebrated oculist died recently at the age of 77 years.

We regret to notice the sudden death of Mrs. G. O'Reilly, relict of the late Dr. O'Reilly, Hamilton. Three of her sons are members of the medical profession, Dr. Charles O'Reilly, Medical Supt. Toronto General Hospital, Dr. Gerald O'Reilly, Fergus, Ont., and Dr. Ed. O'Reilly, *S.S. Peruvian*.

**BROMIDE OF ARSENIC IN PIMPLES.**—It is stated on the authority of Dr. Piffard of New York, that bromide of arsenic is a cure for pimples. The dose is one to two minims of a one per cent. solution three times a day.

**BRANTFORD HOSPITAL.**—The "Stratford" Hospital, Brantford, will be formally opened by the Lieut.-Governor on the 10th inst. The Governors for 1885 are J. H. Stratford, Dr. Digby, Mayor Scarfe, Dr. Harris and Ald. Heyd.

**BRITISH DIPLOMAS.**—It affords us much pleasure to state that Dr. R. J. B. Howard, son of Dr. R. P. Howard, of Montreal, has recently obtained the F.R.C.S., Eng.

**CHANGE OF ADDRESS.**—The manufacturers of the Tucker Truss have removed from 123 Church Street to 274 Yonge, E. A. Smith's late address. See advt.

The Queen has appointed Prescott Hewitt, Bart., F.R.S., Sergeant-Surgeon in ordinary in place of the late Mr. Hawkins.

Dr. Sullivan, of Kingston, has been made a life senator of the Dominion of Canada. We congratulate our worthy confrère upon his appointment.

**CORONER.**—Dr. J. O. McGregor, of Waterdown, has been appointed Coroner for the Co. Wentworth.

## Books and Pamphlets.

**THE POPULAR SCIENCE MONTHLY FOR JANUARY, 1885.** New York: D. Appleton & Company. Fifty cents a number, \$5 a year.

The January number of "The Popular Science Monthly" teems with thoughtful and practical articles. The first is "A Glance at the Jury System," by C. H. Stephens, who makes the defects of the system very evident, and shows that it was not established as a bulwark of popular liberty. In "Agnostic Metaphysics," by Frederic Harrison, "Last Words about Agnosticism," by Herbert Spencer, the religious discussion by these able thinkers may be said to be closed, for Mr. Spencer states that he shall say no more. "Influences determining Sex" by Prof. W. K. Brooks gives the results of a curious scientific research. The story of Tyndal's student-life, told by himself, under the title "My Schools and Schoomasters," will be eagerly read. "Studying Germany," by Horace M. Kennedy, contains valuable information for American students. J. H. Pooley, M.D., describes that curious affection, "Bloody Sweat"; W. M. Williams writes on "Condiments" and "The Cookery of Wine"; and "Protective Mimicry in Marine Life," by Dr. W. Breitenbach; "The Advantages of Limited Museums," O. W. Collet; "The Architecture of Town-Houses," by R. W. Edis F.S.A.; and "Mountain Observatories," are all valuable articles. The subject of the portrait and sketch is that eminent chemist Sir Henry Roscoe.

**DISEASES OF WOMEN,** by H. MacNaughton Jones, M. D., F.R.C.S.I. & E. New York: W. Wood & Co. Toronto: Williamson & Co.

Those who desire to obtain, at a minimum cost of time and money, a better acquaintance than the present educational facilities of this country present to the aspirants for gynecological celebrity, will find in this work of Dr. Jones, conveyed in clear and plain terms, if not all that the modern infinitude of female diseases may seem to demand, yet perhaps sufficient to serve their more pressing needs, not only in the line of positive instruction, but also in that which is not less useful to the ambitious neophyte,—salutary admonition. To the admirers of the gynecological *armamentarium* the 180 well executed plates contained in the book, must give it an attractive prestige, whilst to the

budding specialist they may prove profitably deterrent, until his finances may enable him to procure a more complete gynæcological equipment.

**HENKE'S ATLAS OF SURGICAL ANATOMY**—A SERIES OF PLATES ILLUSTRATING THE APPLICATION OF ANATOMY TO MEDICINE AND SURGERY—Translated by H. A. Rochester, M.D., Lecturer on Pathological Anatomy, Miami Medical College, Cincinnati: A. E. Welde & Co., 1884.

This fine volume reflects credit on the enterprise of the publishers. It contains eighty-one plates, which have been executed with rare skill. These plates may be regarded as a supplement to any text-book of anatomy or any atlas of descriptive anatomy, filling the niche which they have left vacant. They will be valuable to students and practitioners. To the former as a means of fixing in their minds the lessons learned in dissection: to the latter accurate pictures are presented of the connections and relations of the viscera, as well as of the appearance of parts, just as they are exposed by the surgeon during operations. The price at which it is offered is very low (\$10). This work ought to command a large sale.

**ADAMS' HISTORICAL CHART**; with Maps of the World's Great Empires. New York:—Colby & Co., 5 Union Square.

The object of Adams' Chart is to picture history, and to so arrange and tabulate the subjects of history that men, events, and nations, may be located in time by being seen in their positions on the charts as the school atlas locates places. To accomplish this, the chart is divided by perpendicular lines into the 59 centuries and their decades, and colored lines passing from left to right represent different nations, change of rulership being indicated by change of color. The rise, progress, and fall of nations are prominent features in the chart. The plan is so simple that children can readily understand it, and so comprehensive that it is in itself an historical cyclopædia for the mature scholar. An explanatory key accompanies the chart. It is published in three forms, on rollers, portfolio, and book form. Price from \$10 to \$15.

**THE MONTREAL DAILY STAR**.—Carnival number, 1885. Montreal: Graham & Co. Price, 15cts.

This is a highly creditable production, and is in great demand. It contains besides choice reading matter, beautiful colored plates of the various

carnival scenes both real and imaginary; the allegorical representation of the carnival; the skating carnival representing the various costumes worn; the "Tandem Club" turn out; the ice lion, and the ice condora; representative ancient and modern houses in Montreal; tobogganing slides; the ice palace; the politicians at the carnival; storming the ice palace; snow shoe club, etc. etc. It is one of the best productions of its kind ever printed in Canada, and reflects no small credit upon the publishers.

**THE LONDON MEDICAL STUDENT, AND OTHER COMICALITIES**, selected and compiled by Hugo Erichsen, M.D., author of Medical Rhymes. Published by Dr. H. Erichsen, 11 Farmer St., Detroit, Mich. Price, \$2.00.

This interesting compilation is admirably adapted to instruct and amuse the busy practitioner in his leisure moments, or while waiting on the sometimes slow process of nature in the lying-in room. The London Student was originally published in *Punch* half a century ago, and the authorship was variously assigned to Hood, Dickens, Thackeray, Mark Lemon and Douglas Jerrold. It is a very amusing satire on medical student life in those days. A number of amusing anecdotes chiefly of a medical character complete the volume.

**MANUAL OF ORGANIC MATERIA MEDICA**, for the use of Students, Druggists, Pharmacists, and Physicians, by J. M. Maisch, Phar. and Prof. of Materia Medica in the Philadelphia College of Pharmacy. Second edition, with 240 illustrations. Philadelphia: Lea, Bros. & Co. Toronto: Williamson & Co.

The author is well known as the joint author of the *National Dispensatory*, and the work may be regarded as a companion to the Dispensatory. It is adapted for the use of students as an aid in systematic instruction, filling a position which could not be done by the larger work. The author gives in a concise form the *essential* physical, histological, and chemical characters of organic drugs. The classification, which is according to the origin of the drug, is the author's, and while he is "conscious of its imperfections believes it to be convenient and capable of practical application."

**MICRO-ORGANISMS AND DISEASES**, by E. Klein, M.D., F.R.S., New York: McMillan & Co. Toronto: Williamson & Co.

This is a valuable little work which must prove

very useful to those who desire to acquire an introductory knowledge of the important subjects treated of in it. The work is a small octavo of 191 pages, in small but neat type. It contains no less than 108 illustrative plates, which must materially aid the reader in his study of this interesting and useful department of modern medicine.

**THE BASIC PATHOLOGIC AND SPECIFIC TREATMENT OF DIPHTHERIA, TYPHOID, ZYMOTIC, SEPTIC, SCORBUTIC AND PUTRESCENT DISEASES** generally, by George I. Ziegler, M.D. Philadelphia, G. I. Ziegler. Toronto: Williamson & Co. Price, \$2.00.

This work contains a general summary of the basic pathology and specific treatment of the above diseases from the author's point of view, viz: the pathogenic factor, ammonia engendered from within or introduced from without the economy. The work is very interesting and will well repay a careful perusal.

**ELEMENTS OF PRACTICAL MEDICINE** by Alfred H. Carter, M.D. New York: D. Appleton & Co. Toronto: Williamson & Co.

It is only necessary to mention in evidence of the high appreciation of this work by students preparing for final examination that within a comparatively short time a third edition has been called for. The work is compact and comprehensive, and will be useful as an aid, and convenient for reference, to students in attendance on lectures or clinics.

**HOLDEN'S ANATOMY.**—A Manual of Dissection of the Human Body, by Luther Holden, late President of the Royal College of Surgeons, England, etc. Fifth edition. Edited by John Langdon, Lecturer on Anatomy at St. Bartholomew's Hospital, etc. With over two hundred illustrations. Philadelphia: P. Blakiston, Son & Co. 1885. Toronto: Willing & Co.

This excellent work on practical Anatomy has many points of special merit to commend it as a manual of dissection. The descriptive part is concise and accurate, the relative situation of parts is made clear, and many valuable practical suggestions are thrown out here and there as to diseases and injuries which are liable to occur in the part under consideration. A number of new diagrams and illustrations are introduced in the present edition, and more space is given to the consideration of the anatomy of the nervous system.

**THE PHYSICIAN'S POCKET DAY-BOOK**, by C. Henri Leonard, M.A., M.D., Detroit, Mich., 1885.

This will be found a most admirably arranged companion to the practitioner. It differs from most of its kind in having no other matter except the daily record of business, obstetrical memoranda and miscellaneous accounts.

**DRUGS AND MEDICINES OF NORTH AMERICA.** A Quarterly Journal devoted to the botany, pharmacy, and therapeutics of the medical plants of this Continent. Cincinnati: J. & C. Lloyd.

We have received the first and second numbers of this interesting and practical Quarterly. The work is an entirely new venture, and has a wide field of usefulness before it.

**TEXT-BOOK ON HYGIENE** by Dr. George H. Rohé, Professor of Hygiene, College of Physicians and Surgeons, Baltimore. Toronto: Hart & Co.

The above work is an admirable compendium of Sanitary Science and well adapted for students.

**MANUAL OF BANDAGING** by C. Henri Leonard. Second Edition. Revised and Enlarged. Published by Illustrated Medical Journal Co., Detroit.

**RELATION OF ANIMAL DISEASES TO THE PUBLIC HEALTH**, and their Prevention, by Frank S. Billings, D.V.S. New York: D. Appleton & Co. Toronto: Hart & Co.

**CONSUMPTION**, its Nature, Causes, Prevention and Cure, by J. M. W. Kitchen, M.D., Assistant Physician to the Bellevue Hospital. New York: G. P. Putnam's Sons. Toronto: Hart & Co.

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## Births, Marriages and Deaths.

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On the 23rd of December, 1874, Dr. J. W. Sparrow, of Teeterville, Ont., aged 45 years.

On the 20th December, 1884, Dr. J. McDowell, of Shawville, Que., aged 35 years.

On the 4th ult., at Port Arthur, Dr. Lorne C. Campbell, aged 35 years.

On the 13th ult., Dr. O. T. Heartwell, of Dunnville, Ont., aged 36 years.

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*\*\* The charge for Notices of Births, Deaths and Marriages is Fifty Cents, which should be forwarded in postage stamps with the communication.*

# THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

VOL. XVII. TORONTO, MARCH, 1885. No. 7.

## Original Communications.

### A CURIOUS CASE OF MALARIAL NEURALGIA.

BY F. KRAUSS, M.D., TORONTO.

Prof. Med. Jurisprudence Woman's Med. College.

On the 16th of March, 1884, I was sent for to attend Mrs. J. N ——. æt. 33, who was suffering from a severe attack of neuralgia. The patient's appearance presented all the characteristics of the malarial cachexia; she was much emaciated, and her complexion was considerably jaundiced. The history of the case is a peculiar one. For three years previous to 1881 she had resided in different malarious districts in Michigan, but enjoyed complete immunity from malarial symptoms until April in the year mentioned, when she was prostrated by an attack of intermittent fever, which continued, with more or less severity, for three months, the paroxysms being quotidian. In the fall of the same year occurred the first of a series of periodic attacks of neuralgia which have since been maintained with unvarying regularity as to time of occurrence and succession of symptoms. Previously to her illness the woman had always enjoyed perfect health, was strong, vigorous, and active. Family history good.

The characteristics of the periodical neuralgic attacks—as described by the patient and her husband—are as follows: Each attack consists of a “period” of nine days, and occurs twice in the year—in the spring, about the time the snow is disappearing; and in the early winter just before the first appearance of the snow. The paroxysms are quotidian and retarding, that on the first day setting in about 8 a.m., and each successive one about an hour later than on the preceding day. They also gradually decrease in length of duration, usually terminating, no matter at what hour they begin, at about 9 or 10 p.m. The individual

paroxysms much resemble those of intermittent as to succession of events. Each is preceded by marked coldness of the extremities, especially the feet; the other symptoms of the prodromic stage are wanting. Anorexia is persistent throughout the entire period; no vomiting. Violent throbbing, referred to the back of the right orbital cavity follows, and ushers in the cold stage. The latter only differs from the same stage of intermittent in the co-existence of neuralgia. The throbbing behind the right orbit is intensified by excruciating lancinating pain in the same situation, and, in a less degree, along the course of the right supra-orbital nerve. There is also a sense of tension and pressure behind the globus, and which the patient describes as being such as might be occasioned by the presence of an abscess. The whole region about the affected eye is tender; much photophobia exists, with redness of the conjunctiva, and a copious flow of watery fluid from the eye, which the patient declares excoriates the skin of the cheek. Movements of the orbit are attended by a grating sensation. The other eye is unaffected. During this stage the patient maintains an erect sitting posture and complains of a sensation of great distension in the head. Pain in the frontal sinuses precedes, accompanies, and succeeds the cold stage; there is no præcordial oppression. The pain during each paroxysm is remittent, each access being limited to three or four minutes and rapidly followed by another, the entire stage lasting from half an hour to an hour. The hot stage now supervenes, with a cessation of the neuralgic pain and the throbbing, only a feeling of soreness and tenderness remaining. In an hour or two the pyrexia abates, and the sweating stage sets in. The patient, utterly exhausted, falls asleep, and usually sleeps until morning.

The above succession of symptoms is repeated daily—but commencing each day at a later hour—until the ninth day, when a curious phenomenon is described as invariably occurring. The upper eyelid on the affected side becomes ecchymosed, and during or after the sweating stage the patient experiences “a cracking sensation, as if something had given way,” at the chief seat of pain, accompanied by immediate and sudden relief from the feeling of tension and pressure. In her own words, “an abscess seems to burst;” and she insists that a discharge of pus into the pharynx takes place.

She is now free of her enemy for the next six months, although, since the occurrence of the first neuralgic manifestations she has had frequent intercurrent attacks of true intermittent, more especially during her residence in a malarious district. In 1883 she and her husband removed to Canada—first to Hamilton and then to Toronto—and since that time she has had two attacks of true intermittent, one following the death of a favorite child. In every instance the *ague* was quotidian, the paroxysms beginning about 7 p.m. For a month after each neuralgic attack the patient suffers more or less from dull pain about the eye, asthenopia and tenderness of the scalp; a herpetic eruption makes its appearance about the lower lip, and desquamation of the cuticle occurs over the greater part of the surface of the body. Shortly before each neuralgic period the face assumes a deep lemon hue, but this disappears a week or two afterwards. The urine is at all times high colored, and during the neuralgic periods is deeply tinged with bile. The patient can prognosticate the approach of a semi-annual attack by the occurrence of vertigo on stooping, and by the appearance of the yellow tinge over the face.

Variations of the phenomena described have been noticed on two or three occasions. Thus, in the fall of 1882, the period came on after the patient had contracted a severe cold, and lasted ten days, with the usual retarding paroxysm on each. In no other instance has the duration exceeded nine days. In the spring of 1883 the neuralgia, for the first and only time, was seated in the left eye, the right being unaffected. The phenomena which manifested themselves on previous occasions, when the right eye was the seat of pain, were exactly repeated on the left side—including those indicating the termination of the period—but with the addition of a purulent discharge from the left ear—the only occasion on which this has been observed. In the fall of 1883 there was no well-marked period; some fever and a sense of fulness in the head occurred at the usual time, but disappeared three or four days later. There were no chills whatever. The contrast between this incomplete attack and the fully developed periods, in which the chills are the marked feature, is strikingly suggestive of that between the so-called “dumb *ague*” and intermittent of the “shaking” type. A still more curious variation is noted fur-

ther on as occurring during the period which came under my own observation. The patient has also noticed that with each recurrence of the semi-annual attack the pain in the orbital cavity appears to extend further backwards. After the first neuralgic attack, in the fall of 1881—for which the patient was treated in Michigan—onychia developed, first on the right then on the left hand, with subsequent shedding of all the nails; there was much salivation; the enamel scaled from the teeth, especially the molars and bicuspid; the teeth were loosened and later on broke off at the neck, without any appearance of caries. There was also considerable *œdema* of the lower extremities. The patient and her friends attribute these occurrences to the drug employed, and which, I am given to understand, was administered by “a sort of horse-doctor.” It is described as a white powder, with a slightly sweetish taste. Although only half the quantity prescribed was taken (at bedtime), violent delirium set in and lasted throughout the night. The symptoms just detailed followed a few days later. The toxicologist will be inclined to regret the fact that the further services of the horse-doctor were dispensed with.

I saw the patient for the first time at 4.30 p.m. on the 16th of March, the third day of the period. On the first day, the 14th, the attack had commenced at 8 a.m., and was ushered in by the usual coldness of the extremities, and—a symptom hitherto not experienced and not since repeated—neuralgic pains down the back of the neck and along the whole length of the spine. The other symptoms as usual. The second paroxysm, on the 15th, had commenced at 9 a.m., and was less violent than its predecessor. On the 16th the paroxysm did not occur until 1 p.m., and when seen the patient was in the sweating stage. An examination revealed an *anæmic* murmur in the vessels of the neck, and the palpebral conjunctiva was found to be almost colourless; the face of a deep lemon tint, the skin on the affected side—the right—unnaturally dry, and the hair, especially on the right side of the head and about the right temple, turning grey; tongue slightly coated; bowels regular. In the hope of witnessing a paroxysm, and thus being able to verify the patient's statements, I postponed treatment.

March 17.—At 3 p.m. no marked paroxysm had occurred, though the patient had suffered during



the morning from feverishness and sense of fulness in the head. Both this and yesterday morning she experienced "a trickling sensation" in the upper and back part of the nose, followed by the discharge of a few drops of blood from the left nostril, which appeared to give immediate relief. This had never occurred before she said. Pulse, when seen, 80; temperature 99°. Ordered the following mixture:—

R. Quin. Sulph ..... ℥. ij,  
 Acid hydrobromic..... ℥. ss,  
 Extr. gelsemii fl..... ℥. xl,  
 Ol. caryophylli..... m. vj,  
 Elixir. adjuvantis (Caswell &  
 Hazard)..... ℥. iv,  
 Aq. ad..... ℥. viij.—M.  
 Sig.—℥. j. o. h. 4 t℥ sum.

March 18.—Saw patient at noon. Marked cinchonism; no paroxysm so far; she says the pain "is there, but the medicine is holding it back." Ordered half doses of the quinine mixture. On calling again at 4.30 p.m. found the patient in the height of a paroxysm, being the third since I had left her shortly after noon. The first of these occurred about 1 p.m., the second about 2.30, and the third at 4. This last was described as the most severe yet experienced. When seen the patient was in the cold stage; pulse 88, temperature 99½; unable to lie down; great photophobia; pupils dilated, although she has taken half a grain of morphia *per orem* in divided doses since one o'clock. In addition to the intense pain behind the right orbit there was a constant dull pain in the frontal sinuses and across the interorbital space. No pain whatever below the level of the floor of the orbital cavity. Action of the rectus internus and obliquus superior induced acute pain; that of the rectus externus and obliquus inferior some pain, but of a less severe character; contraction of rectus superior gave rise merely to a slight "pricking" sensation; while that of the rectus inferior was unaccompanied by pain or uneasiness. No discharge of watery fluid from the eye, nor redness of the conjunctiva; no *bruit* on auscultating the temple or globus. Pressure on the right temple seemed to give relief, and was repeatedly asked for. Tremor, mainly confined to the lower jaw. For a few moments the patient appeared to be delirious; she declared her head was a balloon and was sailing out of the room, and at the same time craned her

body forwards as if compelled to follow it. Also complained of neuralgic pains in the stomach. Gave morph. sulph. gr. ¼ hypodermically; pain soon after subsided and the patient fell into a dose. Half an hour later her pulse was 84, temperature 99°; pupils still dilated.

March 19.—At 4 p.m. pulse 84; temperature 99½. No paroxysm to-day; slight feverishness early in the afternoon. Patient complains only of slight headache and the usual symptoms of cinchonism. Vomited this morning, food and mucus, streaked with blood. No pain elicited on pressing on the teeth. Continued the quinine, gr. ijss. every four hours without the gelsemium.

March 20.—Vomited again this morning as before. A little feverishness about noon; chilly sensations with slight throbbing behind the orbit at 3 p.m., but when seen at 4 p.m. this had nearly disappeared. Pulse 104; temperature 99½. Eruption beginning to make its appearance about lower lip. Another slight access of fever at 6 p.m. No paroxysm proper during the day.

March 21.—Patient in a state of extreme nervous depression owing to an accident to her son. At 5 p.m. pulse 96, almost imperceptible; temperature 98½. Complained of "pains in all her bones."

Thenceforth the patient made a rapid recovery, without the appearance of any of the phenomena described as attending the close of the period. She was put upon quinine and iron (Vallet's mass), to be continued until the usual time of the fall period should have passed. Early in May she was doing well and looking more healthy, and I have not seen her since.

## BORO-GLYCERIDE IN THE TREATMENT OF SUPPURATIVE DISEASES OF THE MIDDLE EAR.\*

BY A. M. ROSEBRUGH, M. D., TORONTO.

Boracic acid and glycerine, when heated, combine to form a new substance, namely, boracic glycerine or boroglyceride. The proportion is according to their atomic weights boracic acid 62 parts, and glycerine 92 parts. They are gently heated over a water bath. The boracic acid is gradually added to the glycerine, and the heat con-

\* Read before the Ontario Med. Association, June, 1884.

tinued until 54 parts, or 3 molecules of water, are driven off. The boroglyceride "on cooling is an amber colored vitreous mass, which is very friable and easily broken. It is readily soluble in glycerine, but less so in hot or cold water (about 10 per cent)." "It has an acid, pungent taste, and an astringent effect when applied to mucous membranes."

This new substance or compound is an antiseptic, and if we mistake not is determined to play an important rôle in the antiseptic surgery of the near future.

I believe it was the great author of antiseptics, Prof. Lister himself, who first suggested that suppurative diseases of the middle ear should be treated antiseptically. An antiseptic dressing, in order to be effective, must insure two important conditions, namely, complete exclusion of the air, and perfect disinfection of the whole suppurating surface.

In otorrhœa, where the drum cavity communicates with the external auditory canal, by means of a perforation of the drum membrane, it would seem, at first sight, to be impossible to secure these conditions. Stimulated however by the success of antiseptics in general surgery, the profession long since commenced the use of antiseptic solutions and powders in the treatment of purulent middle ear diseases, but with only partial success. Weak solutions of carbolic acid ( $\frac{1}{2}$  to 1 per cent.) were found to be useful for cleansing in cases of caries or necrosis of the bone, but it caused an increase in the secretion and a more swollen condition of the tympanic mucous membrane. Salicylic acid in alcoholic solution was used in chronic cases, but it was not well borne in acute cases. Iodoform, either alone or combined with other powders, as alum or oxide of zinc, has also been extensively used, but many object to it on account of the smell.

In 1879 Prof. Bezold, of Munich, commenced the use of boracic acid in the treatment both of acute and chronic cases of suppurative inflammation of the tympanic cavity, and with most encouraging results. He reported in that year 145 cases that had been treated with the boracic acid—29 with acute, and 116 with chronic suppuration. Of the acute cases, the average duration of the discharge was only 13 days; and of the chronic cases the average duration of the treatment, until all discharges ceased, was only 19 days.

After trying saturated solutions of boracic acid, and getting no better results than were obtained from other antiseptics, he tried filling the meatus with very finely pulverised boracic acid, and with the result as just reported.

"He asserts that this method of treatment is so much more certain, and so much quicker than other methods, that he now uses it in every case of suppuration, either of the meatus or tympanum, and also after lesser operations, such as the removal of polypoid granulations, cauterization and paracentesis; he excepts, however, extensive disease of the bone and perforation of the mastoid. He does not consider that it supplants, but rather assists other methods of treatment, like the antiseptic dressing in surgery; cauterization of granulations, removal of polypi, etc., are still as necessary as ever."

"The meatus and tympanum are first cleansed carefully with a four per cent. solution of the acid, then dried thoroughly, and finely pulverized boracic acid blown in over the suppurating surface; the meatus is then closed with salicylic, carbolic or boracic cotton."

"The pulverized acid has the advantage of producing no re-action on the mucous membrane, of withdrawing the water from the membrane which keeps a saturated solution in contact with the inflamed surface, and of not forming coagulations with the secretions. In cases of otorrhea, complicated with phthisis of the lungs, the acid had no effect on the discharge." The use of the boracic acid powder, however, is attended with certain drawbacks. 1. Its application is somewhat inconvenient. 2. It retards the free exit of the discharges. 3. In some cases there is a tendency for the powder "to cake," which renders the thorough removal difficult. 4. It fails to completely remove the odor.

Boroglyceride is free from these objections. It removes the odor almost immediately, and is so easily applied, that in some cases the application may be entrusted to the patient. With its use I have also succeeded in causing granulation tissue to disappear without resorting to the use of chromic acid or the other caustics. It is used as follows: The ear is carefully syringed with a warm, almost hot, saturated solution of boracic acid. Politzer's air bag, or the eustachian catheter is used to force the discharge from the middle ear through the perforation into the external auditory canal. The syringe is again used, and the fundus of the meatus dried with borated cotton, attached to the end of a probe.

The ear mirror is now used, and, if necessary, the cotton used again and again until all the discharges are thoroughly removed. The head is bent to the opposite side, and the upturned ear is half filled with the warm solution of boroglyceride. While the head is in this position air is forced through the eustachian tube, middle ear and perforation, and through the column of medicated fluid. In addition to this the tragus is pressed backwards and inwards, so as to compress the air over the fluid. Both these procedures favor the passage of the boroglyceride into the middle ear. If the patient is unable to force the air through the eustachian tube—the catheter or the air douche is used. A plug of absorbent cotton, soaked in vaseline is used to prevent the boroglyceride from escaping. The patient is seen two or three times a week, and in the meantime the ear is to be syringed with the boracic acid solution, and the boroglyceride applied night and morning at home. The boroglyceride is used in solutions of glycerine varying in strength from 10 to 100 per cent. according to the case. Dr. R. C. Brandeis, of New York, who has been using this remedy for the last two years, commences the treatment with the more concentrated solutions, and diminishes the strength as the mucous membrane assumes a healthier condition, and as the discharge diminishes.

"This remedy, he states, has enabled him to discharge patients as cured in from three to four weeks, who, he is sure, under the old methods, would have been under treatment as many months.

With a view of making the history of boroglyceride more complete, I may add, that in March, 1882, Prof. Barff read a paper before the London Society of Arts, "On a New Antiseptic Compound and its Application to the Preservation of Food," etc. This paper was published in the *Journal of the Society*. In the *British Medical Journal* for April 29th, 1882, Mr. Balmanno Squire suggested that the new compound be given a trial in antiseptic surgery. This led Dr. Brandeis to use it in aural surgery, the result of which he reports in *The Archives of Otology* for April, 1884.

### CHARCOT'S JOINT DISEASE.

BY C. L. COTTON M.D. COWANSVILLE, QUE.

GENTLEMEN.—As the subject of Charcot's joint disease has recently attracted a good deal of attention, I trust a few notes of a case, which I have under my observation, may prove of some interest to this meeting :

H. G., aged 42, a native of England; engaged in the dry goods business in New York during 14 years. He has a good family history; no case of

nervous disease that he can discover. He had convulsions when a child, but enjoyed generally good health until 1876 when he noticed strabismus of both eyes. He had one eye operated on in Glasgow and the second in Paris, since which time he has had no further trouble with his eyes. In looking back he can notice some failure in his gait in 1879, which was soon followed by neuralgic pains in his legs. These began quite suddenly. He can remember distinctly the place and hour when he had the first attack. He describes them as the usual pains of locomotor ataxia are described—as lightning-like pains. These have continued until the present, each attack lasting two or three days, and then an intermission of two or three weeks. He also had a cord-like feeling about his waist and a weakness in the knees.

He first came under my notice in December, 1879, when he presented very typical symptoms of locomotor ataxia. His walk was quite ataxic, could not stand with his eyes closed. Patellar reflex absent; complained severely of the feeling of girdle pains; some loss of power over the sphincters and diminished cutaneous sensibility in the legs. He continued in very much the same condition, but with a gradual failure of co-ordination until July, 1883, when one day while using a saw in such a manner that his right leg was put into a swinging motion over the edge of the box, the under surface of the thigh coming in contact with the box, he noticed immediately afterwards his knee very much swollen, and during the day the leg, foot and toes were involved in the swelling. There was a slight purple discoloration on the under surface of the thigh. My attention was called to it about ten days later; there having been no pain about it from the first, it had been looked upon as a simple sprain. I found the knee and leg as far as the ankle much swollen, the joint full of fluid and crackling on pressure. It had the appearance of a joint undergoing rapid disorganization. His present condition one year since the knee was first affected will be seen by the appearance of these photographs. The joint is enlarged; the lower end of the femur appearing to be much enlarged. There are no apparent bony outgrowths. Both bones of the leg are dislocated outwards, though they can be readily replaced, and in doing so give rise to a sound as if the ends of the bones were quite worn away. There is no fluid in the

\*Read before the Canada Med. Association, August, 1884.

joint, no crackling feeling present. The veins are much enlarged over the knee. Both legs are much wasted; patellar and plantar reflexes absent; cutaneous sensation entirely absent in the feet, legs, and lower half of the trunk. He can support part of his weight on the diseased knee, but is afraid to do so; consequently he does not attempt to walk, but gets about comfortably in a wheeled chair. Appetite good. Digestion somewhat at fault, but generally fair. Sexual power lost during the last twelve months. The sphincters are weakened. At times he can control his bowels and bladder; at other times he finds it impossible to do so. Has never had gastric crises, and never felt any pain in the affected knee. Girdle pains have disappeared. In reference to the loss of sensation, it is curious to note that he has a large corn on one foot which often causes him severe pain. He complains of much numbness in his fingers.

The question of the relationship of joint affections occurring during the course of locomotor ataxia with the special lesion of the spine has been very freely discussed during the last few months, giving rise to papers at the clinical and pathological societies of London. Charcot, whose name has been associated with this disease, in his earlier observations attributed it to the anterior cornua of the spinal cord becoming involved in the diseased process. But further post mortems showed that the disease could be present without lesion of the anterior cornua being demonstrated. Dr. Buzzard is strongly inclined to the opinion that the pathological centre is to be found in the medulla oblongata and brings forward as an evidence the frequent presence of laryngeal, gastric and intestinal affections (more than 50 per cent.) associated with bone joint troubles. Sclerosis attacking the vagus centre is in short his theory. Thus far there has been no discovery of a joint centre in the nervous system, and it would seem that, with the close pathological study that has been given to "centres," if such a centre existed, the question would have been set at rest before this. Charcot depends chiefly on the clinical features and pathological changes in his assumption of this being a distinct specific arthropathy. Another view of the pathology of these cases is that they are an ordinary arthritis modified by the conditions of the patient. In support of this view are the very similar joint changes noticed after injuries to nerves. Weir Mitchell, Si-

Wm. Gull, Ziemssen and Charcot have all noticed cases of arthritis due to nerve lesions, and it is a question whether rheumatism has its origin in the nervous system. These lesions are usually ascribed to the inhibition of the trophic influence of certain nerves. The third view of the pathology of these joint cases is that they are ordinary rheumatic or other forms of arthritis occurring in ataxic patients independently of their nervous disease. My experience of these cases being limited to the one under discussion, I must leave the question of pathology to others who have had more experience. But I must observe the course of this case has been different from any joint affection that has come under my notice. The entire absence of pain, the rapid disorganization of the joint, with the history of a slight injury, would incline me to the view, that, firstly, there must have been a predisposition to joint affection, otherwise so slight an injury could not have caused such a serious effect; and secondly, that the trophic nerves, and I think that it is generally admitted that certain nerves have trophic influence, must have become seriously impaired in their function. If these joint affections occurring in locomotor ataxia are not specific arthropathies, and I do not think that this has yet been proved to a certainty, there is no question in my mind that they are strongly modified by the diseased nerve influence.

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### Correspondence.

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To the Editor of the CANADA LANCET.

SIR,—I noticed in the last number of the LANCET a communication from Cornwallis, N.S., signed "A Resident Physician," directing attention to the want of medical ethics displayed by some of the fraternity in that locality. If the writer of that communication were to visit a small town, not far from the metropolis of Ontario, I could point out to him some specimens not to be excelled by the most astute thimble-riggers our friends by the sea could produce. The mode of operation adopted by the medical trickster, "down by the sea," does not indicate any great amount of shrewdness, and differs somewhat from that adopted by his species in this locality. He depends too much, I fear, upon himself and his "helpmeet." He should imitate his friend in the west, by forming a "petticoat brigade," with himself as head Beadle—

his "helpmeet" President, and his sister-in-law, should he chance to have one, as Vice, things could be worked nicely. The rank and file might be filled by the confidants of the president and vice. Thus arranged, if called to consult another physician, say in a case of confinement, he might whisper the assurance to his wife, or her sister that his timely presence had saved the friends of the patient an undertaker's bill. The president and vice could mention it cautiously, and, of course, quite casually to their lady confidants, and they, in turn, through the promptings of the president and vice, might be relied on to retail the news to the whole circle at the next afternoon "tea-party" they attended. In this way superiority and skill could be made known, and by a little indirect manoeuvring the whole female community might be let into the secret—especially that part of the community likely to prove of interest to the accoucheur. The Nova Scotian, like his brother chip in this part of the Dominion, might facilitate operations to some extent by taking in a partner. The partner needn't necessarily be gorged with medical lore. He would require to be a sort of "free and easy," and be stocked with a liberal amount of conceit. His usefulness would depend very much upon his cheek; his inability to take a rebuff, and upon his ability to fix up a plausible story. In order to prove a success he would require to force himself, in a social way, into the houses of other physicians' patients, and by a little hinting and winking endeavor to create an impression that the family physician had made some remark reflecting on some of the lady members of the family. He might, at the same time, do a little puffing on his own hook—give, say, in an indifferent sort of way, a synopsis of cases "placed specially under his care," and let the public know what gratitude is due to him by suffering humanity. There are a hundred and one other ways by which our Nova Scotian friend might become enhanced in the eyes of an unsuspecting public, and should he become cornered in a treacherous and dishonorable act, he will differ very much from those of his kidney here, if he don't throw dirt and call in the assistance of his tools and minions to cover his guilt. The fact is the slipshod, artful, half positive, half negative physician, is the same kind of an animal wherever you find him, varying only in the manner he may adopt, and the facilities he may possess for per-

forming his tricks. By all means let the Nova Scotia man have a chance, for, like his Ontario prototype, he may have only his tricks and shams, and "petticoat brigade" to depend on.

Yours, &c.,

A RESIDENT PRACTITIONER.

February 13th, 1885.

### Selected Articles.

#### BONY UNION IN INTRACAPSULAR FRACTURE OF THE FEMORAL NECK.

Dr. John B. Roberts, of Philadelphia, read the following paper before the Philadelphia County Medical Society in November last:

Much has been said against the possibility of osseous repair occurring after intracapsular fractures of the neck of the thigh bone. It is probable that this teaching has induced more than two-thirds of the general medical profession to believe that bony union of such lesions never occurs. Careful investigation of cases and specimens by competent surgical observers has conclusively demonstrated that such belief is erroneous. Bony union does occur, though not frequently. In my opinion, moreover, its non-occurrence is to some extent due to the violent and unjustifiable manipulation to which injured hips are often subjected, by reason of the attendant's ignorant desire to demonstrate crepitus and preternatural mobility. The diagnosis can usually be made with reasonable certainty without the development of these symptoms of fracture. Therefore, it is unnecessary and improper to imperil the future usefulness of the limb merely to arrive at an absolute diagnosis. In cases of doubt it does no harm to treat the case as one of fracture, even if none exist; but violent manipulation, by tearing connecting bands of periosteum or detaching the impacted fragments, greatly reduces the probability of union.

Union *may* be bony and the function of the joint perfectly or almost perfectly restored; if not bony, the bond of union *may be* a very short, fibrous one, giving as good functional result as osseous repair. Hence, the surgeon should treat his cases as if he expected a good cure; for it is impossible to say that a given patient is one in which no attempt at union will take place. Non-union of intracapsular fracture of the hip is, it is true, often found. I have in mind now a case where the autopsy showed no attempt at even fibrous union. Let us not expect this, however, as a rule, for then we may be led to neglect proper therapeutic measures. Specimen No. 1130<sup>15</sup> of the Pennsylvania Hospital Museum, taken from the patient referred to above, between eighteen and nineteen weeks after the in-

jury, is a good illustration of non-union. It was a transverse fracture at the junction of the head and neck of the bone. Specimen No 1130<sup>20</sup>, from the same Museum, on the other hand, is here shown you; it is described in the Museum catalogue as an intracapsular fracture firmly united; and by longitudinal section shows bony union. The specimen belongs to Dr. T. G. Morton, and was removed from a patient, aged 67 years, twelve years after the accident that caused the injury. There is some evidence of impaction near the base of the neck; and it is perhaps *possible* that part of the line of fracture extended without the capsule. Of this we have no definite evidence, as the ligaments were removed in preparing the specimen. This cast of a specimen is from the Mütter Museum of the College of Physicians, and represents an impacted fracture of the femoral neck in which there was *inversion* of the leg. The patient was under the care of Dr. Conklin, of Ohio.

I have made these prefatory remarks to introduce the clinical history of a patient who has now good use of her limb subsequent to an intracapsular fracture, although treatment was abandoned shortly after the receipt of the injury. She has probably a short fibrous union; possibly a true bony one. In either event, however, the result is gratifying; and teaches that such cases should not be looked upon as necessarily hopeless in respect to union.

She is a German, 78 years old, and was admitted to my ward in St. Mary's Hospital, on August 30th, 1884, after falling from a street car. The resident surgeon believed there was no fracture at the hip; but on my visit I considered that the position of the limb and the patient's age pointed to intracapsular fracture of the neck of the femur. On taking hold of the leg and making rotation without violence I felt indistinct crepitation. At once desisting from further manipulation, I ordered permanent extension by weights and lateral support by sand bags to be the treatment. Within four days incontinence of urine, the development of a superficial bed-sore and the debilitated condition of the patient showed me that there was danger of the aged woman dying. I accordingly ordered the resident surgeon to discontinue the fracture dressing, so that the patient's buttocks and back could be kept clean and the bed-sore properly dressed; telling him that no union of the fracture was likely to occur, and that we must endeavor to save life by tonics, stimulants and food, and the prevention of further bed-sores. I gave a similar prognosis to my Polyclinic pupils who saw the case. Ten days later, that is two-weeks from the time of injury, another incipient bed-sore was noticed on the buttocks. The hospital notes of this date say that I ordered change of posture to be frequently made, and that she sit up as soon as possible. Six days subsequently she was sitting up in a chair. I am unable to say whether she got out of bed previous

to this date or not. The bladder symptoms gradually improved, she soon sat up all day, and on October 4th, five weeks after admission, it is recorded that she was walking on crutches. On October 26th she was able to walk a little *without* crutches, though she did not do so much. She continued to gain in activity until her discharge, on November 2nd.

The result was so unexpected to me, for no restraint of motion at the hip was attempted after four days, that I almost mistrusted my diagnosis, and concluded that possibly the resident surgeon's original diagnosis was correct. I had made no investigation of the condition of the limb since she began sitting up. A few days before her discharge, however, I put her in bed, and with my colleague, Dr. Keen, examined her. The leg was strongly everted, as in intracapsular fracture, immediately after the injury, and she was able to invert it only so far as to make the toes nearly vertical. She could raise the leg, however, and lay it across the other or carry it outward, and, indeed, appeared to have every motion of the joint, except full inversion, though she stated it was a little stiff when walking. She had no pain. The everted leg, therefore, made the correctness of my diagnosis an established fact. Here, then, in a woman of seventy-eight years, was obtained union and a useful limb, despite the absence of treatment. In the face of such result, treatment should always be attempted, and not abandoned unless circumstances, such as arose here, demand its discontinuance. Well directed treatment will certainly be expected to make many good cures, if no treatment will occasionally give so excellent a limb.

## TREATMENT OF TUMORS.

Dr. McNaughton Jones (*Med. Press and Circular*) gives the following advice in regard to the treatment of tumors:

The larger our experience of tumors of the mammary gland becomes, the more do we see the uselessness of trusting to external applications of any kind to dissipate them. Iodide of potassium, iodide of lead, iodine, the oleates of lead and mercury, discutient lotions of chloride of ammonia with camphor, combined with compression, are at times of use in the case of small nodosities, chronic induration after inflammation, and small cystic growths, but they more frequently fail, and unless growth is otherwise arrested, the use of the knife is sooner or later called for.

Lipomatous tumors, small cystic tumors, galactoceles, adenomatous nodules, may remain for years if not permanently, without growing or giving rise to any pain or even uneasiness, and all such growths cause great uneasiness in the mind of the woman, and make her apprehensive and unhappy. I am not so certain that if the rule to completely

remove any circumscribed growths from the mammaræ, whether painful or otherwise were generally acted on we would not be on the safer side than to temporize with any.

Take what pains we may to assure a patient of the harmlessness of any form of breast tumor, there is a natural fear of malignant disease which tends to make her mind dwell on its presence. Also, in the instance of cystic or sarcomatous growths we know sufficient of their liability to assume a malignant nature to make us, even after years of quiescence, wish they were out of the way of harm. The surgeon is perhaps more often in doubt as to the expediency of removal of the mere growth or of the entire mammary gland. His decision must depend on the homologous or heterologous character of the growth, its size, hardness, the puckering of skin, rapidity of growth, the extent of the gland involved, and the other features which make suspicious of its malignant or sarcomatous nature. Small, circumscribed and encysted tumors of a benign type may be carefully removed, but if there are any reasonable grounds for apprehension that the disease is of a malignant nature, or likely to become so, or again, that the tumor is of large size, the best course is to amputate the breast. Encysted tumors containing fluid may be incised, and the cyst cavity treated with some stimulating fluid, as solution of iodine, carbolic acid or chloride of zinc. The nature of the fluid may be determined on previously, by drawing off a small quantity with a hypodermic syringe and examining it so as to ascertain whether it is serous, hydatid or sanguineous. Hydatid tumors must be removed. *The one safe rule in all cases of malignant growth of the breast is early amputation of the entire breast.* If the axillary glands are enlarged, these should be carefully removed at the same time and the entire axilla cleared of all suspicious nodules. The association of eczematous inflammation of the nipple and malignant disease (Paget) must not be forgotten. In a well-marked case of this nature exhibited by me at the Pathological Society of London in 1881 the woman had suffered for over two years from excoriation of the nipple, and when she was admitted to the hospital there was an area of the circumference of a crown piece, including the nipple, of eczematous ulceration (eczema rubrum). Close to the axilla was a hard mass of scirrhus, which had been ulcerated, leaving a raw surface of the vivid red coloring of malignant ulceration. I removed in this case the breast, the incision being about ten inches in length, so as to include the entire area of scirrhus infiltration near the axilla. I dissected away all the glands from the apex to the floor of the axilla. The entire dissection of the axillary structures was as clean as if the part were prepared for demonstration. Yet in one year after the operation the patient returned to the hospital with a huge fungous mass protruding from the left

side of the wound. (This specimen is in the museum of the Queen's College, Cork). Only in one instance of extensive scirrhus have I operated in which there was no return of the tumor. The patient died of an attack of acute inflammation of the lungs about two years after the operation, and the breast had given her not the least uneasiness up to the time of her death. Yet it might have developed subsequently. We may decide the question of operation on these grounds:

1. The size of the tumor and the degree of infiltration of the mammary tissues; the extent to which the skin is involved, as well as the condition of the axillary glands.

2. The general health of the patient and the co-existence of malignant disease elsewhere, or of other serious constitutional disorders, as phthisis or uterine disease.

If we determine not to operate, we must palliate and relieve pain to the best of our ability by such means as compression, anodyne applications, as opium, belladonna, conium and hyoscyamus, in the form either of fomentation, ointment, or strapping, while both morphia and atropine or cocaine may be administered subcutaneously.

In conclusion, I would say in regard to any malignant or suspected malignant tumor of the breast, "Remove early, remove the entire breast, sufficient skin and all suspicious tissues and lymphatic glands.

*Amputation of the breast.*—Perhaps there is no operation in which the benefit of antiseptic surgery is more perfectly illustrated than in this. Union by first intention is the rule. To secure this result we should arrest hemorrhage by torsion, which if properly carried out, and care taken that the wound is not closed until all the bleeding has ceased, I find is quite efficacious, and there is little fear of any secondary hemorrhage. If ligatures are used let them be of carbolized gut. Operate with every antiseptic precaution and dress with drainage tube, and the usual antiseptic dressings. Use silver sutures or catgut to unite the margins of the wound; remove a few of these if there be any undue tension, within forty-eight hours after the operation. Dress subsequently and daily under some antiseptic spray *until the wound has united.* When the wound is healing cover it with a weak thymol or benzoated dressing and a thymol pad.

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#### THE "UNCONTROLLABLE" VOMITING OF PREGNANCY.

A paper on the above subject by Dr. Grailly Hewitt, read before the Obstetrical Society of London, is summarized in the *Medical Times* (November 22). Its conclusions are based upon two series of cases in which the condition of the body and cervix were recorded, and are as follows:—



(1) That the case in which the disease is due to some other organ than the uterus are so few in number (only one in the series of 32) that they may be almost excluded from consideration. (2) That in the large majority of cases the disease presents itself during the first half of pregnancy. (3) That the evidence points to interference with the normal expansion and growth of the gravid uterus as the condition of the production of this dangerous affection, and that this is most frequently brought about by or in connection with retention of the bulk of the uterus in the bony pelvis, in 88 per cent. the uterus being anteverted or anteverged, and in 12 per cent. in a state of retroversion, the other conditions met with being hardness, resistance, or unusual rigidity of the os and tissues of the cervix. (4) There appear to be two factors to be considered capable of interfering with the expansion of the uterus (a) incarceration with flexion or version; (b) undue hardness, and rigidity of os and cervix. These may be conjoined in a given case. It appears to be borne out by the facts recorded that the incarceration is the more important of the two factors, as a rule at least. The facts appear to point to the occurrence of embarrassment in the expansion of the uterus very early in the pregnancy, such as might be expected to be occasioned by a previously flexed state of the uterus or by a congested indurated state of the cervix, or by the two conditions combined. As the pregnancy advances, the congestion and swelling are intensified, and the resistance to expansion thus increased. It appears probable that the particular cause of the sickness observed is the compression of the nerves situated in the tissues which are especially exposed to compression, namely, those around the cervix uteri, and especially those near the internal os. Copeman's success in the treatment of severe sickness by dilating the internal os is evidence in this direction. The importance of the flexion element has been denied, one principal objection being that sickness is not always present when the uterus is flexed. But the case is the same in the non-gravid uterus; severe sickness is not seldom due to flexion of the non-gravid uterus, while flexions are observed without sickness. Corroboration of the author's views are contained in Gehring's recent paper. As a rule, severe sickness is limited to the first half of pregnancy, in a very few cases it persists longer; in these rare cases, the cause may be rigidity of the tissues round the internal os, persisting to a late period. As regards treatment, the first indication is to secure the normal upward movement of the fundus uteri, to relieve the incarceration of the uterus, when present, if that be possible, and to prevent its occurrence by a properly arranged method of treatment. Absolute rest in the supine position if anteversion be present or on the face or side if retroversion be present, and the use of the knee-

elbow position will be required. These measures suffice in many cases. If the uterus be fixed, gentle continuous pressure must be applied internally by the fingers, or by an air-ball, and the position maintained by a suitable pessary. These measures failing, Copeman's procedure of dilating the cervix should be employed. Artificial abortion, will, it is believed, be rendered unnecessary if the less severe measures are applied early.—*Boston Med. Journal.*

#### NEW YORK STATE MEDICAL SOCIETY.

We give below a digest from the *N. Y. Med. Journal* of some of the papers read before the N. Y. State Medical Society on the 3rd, 4th and 5th, ult.

**ACUTE PELVIC ABSCESS.**—Dr. W. W. Potter, of Buffalo, read a paper with this title. The case was one of a large non-puerperal collection of foetid pus behind the uterus, of rapid formation and accompanied with marked constitutional disturbance. The aspirator was employed when fluctuation was well marked, with result of complete relief from pain, but the patient's general condition was still precarious. Various antiseptic injections having been used with little or no result, an iodoform emulsion was introduced into the abscess cavity, after the method used by Dr. Prince, of Illinois, and with the speedy occurrence of improvement. The patient made a good recovery. Before the attack came on the patient had been taking cotton-root tea in large quantities by the advice of an irregular practitioner who had diagnosed ovarian trouble; and it was a question if this had not something to do with causing the inflammation. The author referred to the frequency and importance of pelvic cellulitis, and credited Emmet with having done great service to gynaecology by emphasizing the leading part played by the affection in connection with pelvic disease. As to treatment, the author advocated the radical procedure of prompt evacuation, characterizing it as "the treatment of to-day." It was only by the vagina that pus could safely escape by spontaneous opening, but there was nothing to assure us that the abscess would not break in some other direction if there was no interference with it. The necessity of antiseptic injections into the cavity was insisted upon, and they should be given by the physician himself.

Dr. Wylie, of New York, thought that the abscess must have been due either to an hæmatocele or to the access of septic material from the oviduct. He thought, too, that it was not the cellular tissue that was the seat of the collection, but the peritoneal cavity. He would prefer a trocar and canula, with subsequent dilatation, to a knife for opening such a collection. Caution should be observed in

washing out such a cavity with so strong a solution of bichloride of mercury as a 1-3,00 solution. Many pelvic abscesses, especially those of the cellular tissue, were quite as apt to point elsewhere as in the vagina, and in such, laparotomy with proper precautions, seemed to him the proper procedure, with removal of the oviducts.

Dr. Ely, of Rochester, reported a case of what might be termed "latent pelvic abscess," in a girl of sixteen years. The collection was large when attention was first directed to the abdomen. A large curved trocar was passed into the abdomen, below the umbilicus, and out through the posterior vault of the vagina, and through the canula a drainage-tube was passed. This "through drainage" was speedily followed by recovery.

Dr. Bowditch, of Boston, related a case of pelvic abscess in a child two years of age, that had been treated like Dr. Ely's case, except that a re-accumulation of the pus led to incision and washing out of the abdominal cavity, with the most favorable result. We were still too much afraid of opening the abdomen, as, twenty years ago, we were too much afraid of opening the chest.

**PEROXIDE OF HYDROGEN.**—Dr. S. S. Wallian, of Bloomingdale, read a paper on this subject. It was said that it might take the place of ozone for many purposes, as a germicide, etc., while it was perfectly harmless in the form in which it was used in medicine. It acted by parting with a portion of its oxygen, which, no doubt endowed with the peculiar activity incident to the nascent state, combined directly with septic substances, and thus put a stop to the putrefactive process. The author then gave a summary of its therapeutical applications, with special reference to its use in the treatment of diphtheria. Cases of carbuncle, sloughing ulcer, and septic infection (one of each) were then alluded to as having occurred in the author's practice and having been treated with the peroxide with brilliant results.

**A CASE OF CANCER OF THE LIVER**, characterized by a series of low temperatures, was then related in a paper by Dr. W. S. Ely, of Rochester. An uncommonly full record of temperature observations had been kept. A great number of them showed a subnormal temperature—the lowest being 91° F. There were no signs of collapse at any time, and there was no correspondence between the state of the temperature and that of the pulse, but the patient felt cold to the touch. There could be no error about the observations, as they had all been made by an experienced nurse, with a Hick's thermometer accompanied by a certificate issued from the Yale Observatory. The inferences were, that subnormal temperatures were not always so dangerous as was generally supposed, and that thermometers ought to be graduated lower than was commonly the case.

**TUBAL PREGNANCY.**—Dr. Squire, of Elmira, read an account of a case of tubal pregnancy in which the sac ruptured, peritonitis followed, and the foetus was subsequently felt in Douglas's pouch, together with a large quantity of foetal blood. The collection then burst into the rectum, with marked relief for a time, but subsequently blood-poisoning showed itself, and laparotomy was performed. The effusion was found walled in above by a false diaphragm of lymph exudate, and the operation was abandoned. Nevertheless, the patient at once began to improve, but, some months later, she began to sink again, and died nine months after the rupture of the sac. At the autopsy, an abscess containing about twelve ounces of pus was found in the right broad ligament.

**DOES QUININE ABORT PNEUMONIA?**—Dr. Holt, of New York, read a paper with this title.

Dr. Bell, of Brooklyn, spoke of the malarial origin of cases of pneumonia that he had treated, particularly among children, and in the swamps of the Chickahominy.

Dr. Loomis, of New York, thought the question really was, whether the passive hyperæmia of malarial disease was identical with that of the first stage of pneumonia. Passive hyperæmia, especially in children, gave rise to physical signs that might easily lead to the case being taken for pneumonia; but he did not think such cases of engorgement would go on to the development of pneumonia, except under the influence of something else than malaria. It was impossible to stop the course of a lobar pneumonia—a disease which, he thought, was truly infectious. Was the pneumonia of to-day different from that of fifteen or twenty years ago? In his opinion, there had been no more change in the character of pneumonia than in that of a number of other diseases, such as diphtheria and cerebro-spinal fever.

**SENILE HYPERTROPHY OF THE PROSTATE** was the title of a paper read by Dr. Post. The paper dealt with the subject in a systematic manner, so as scarcely to admit of a synopsis. The author showed a special syringe, of his own device, for attaching to a catheter in the procedure of washing out the bladder. It was so constructed as to admit of repair readily without its being sent to an instrument-maker, and of being attached to any ordinary-sized catheter. Stress was laid on the advantage of using large catheters in cases of prostatic disease, for the reasons that are commonly given. In the use of very flexible rubber catheters, it was sometimes useful to stiffen the distal part of the instrument by coating it with collodion. In very aggravated cases of cystitis, he had found much relief produced by applying the actual cautery to the pubic region. He was inclined to favor a resort to crushing or other operative procedures in some cases of very difficult catheterization, but the opinions of surgeons with regard to these measures were diverse.

**CHOLERA AND QUARANTINE.**—Dr. Van der Poel gave an extemporized *résumé* of his paper on this subject. His remarks had special reference to the question of the probable efficacy of quarantine in preventing the importation of cholera. The speaker gave an interesting description of the measures that were taken on the Red Sea route of travel, under an authority of an international sanitary board, to prevent the transportation of cholera from Calcutta and Bombay: they were almost always efficient, but occasionally the luke-warminess of the British officials thwarted them, a notable instance of which was seen in the landing of a steamer's load of steerage passengers on the western shore of the Red Sea, in order to elude observation, and the consequent spread of the disease to Egypt and thence to France. As to quarantine in the old sense of the term—absolute detention and non-intercourse—that was not what sanitarians now meant when they spoke of quarantine, but the whole system of guarding against the shipment of diseased persons, clothing, etc., when the disease broke out, so as to prevent its extension over a country. If these measures were carefully carried out, there was a great probability of our being able to stamp out the disease in case it made its appearance; but they should include detention and observation for ten days at the ports of New York, Boston, Philadelphia, Baltimore, and New Orleans. The co-operation of the Canadians could probably be counted upon, for they did not share the English view as to the uselessness of quarantine.

#### FORK FOR FRACTURE OF THE PATELLA.

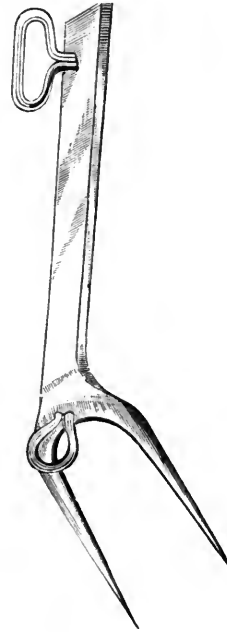
Dr. L. A. Stimson showed before the N. Y. Surgical Society, a fork to be used in the treatment of fracture of the patella. He had expected to show a patient upon whom he had used it with success, but the man had failed to come.

In using Malgaigne's hooks he had found it difficult to insert the hooks deeply enough to adjust the screw that connects them, and he had devised this fork as a substitute. The fork is of iron, two-pronged, the prongs bent in the flat at an angle of forty-five degrees at their junction with the shaft. The prongs are one inch long and three-quarters of an inch apart; the shaft is about three inches long. There is a small ring at the base of the prongs for the attachment of an india-rubber cord, and another at the end of the shaft for the attachment of a bandage encircling the thigh.

The instrument is used by inserting the prongs through the skin above the patella and pressing them down until they rest against the upper border of the upper fragment; the shaft lies along the median line of the front of the thigh, and is prevented from tilting or moving to either side by a roller bandage wrapped around it and the thigh. Trac-

tion downward is made by a piece of India-rubber tubing, one end of which is attached to the ring at the base of the prongs and the other made fast to the front of the skin by adhesive plaster. The introduction of the prongs can be made easily and painlessly by chilling the skin with ice and making two punctures with a knife.

In the case he had treated with this fork the fracture was transverse and the separation about an inch. The separation was readily overcome by the traction. The patient made no complaint during the five weeks the instrument was in place. The patient was kept in bed, with the limb suspen-



ded in a wire gutter, and the punctures kept dusted with iodoform; there was no inflammatory reaction about them, and only a slight discharge. The lower fragment was kept gently pressed upward by an oblique turn of a roller bandage. On the removal of the fork, five weeks after the occurrence of the fracture, the fragments were closely and firmly united, without independent mobility. As a precaution, a plaster bandage was then applied, and not removed until the end of the ninth week. The knee could then be flexed nearly to a right angle, and there was still neither independent mobility nor separation of the fragments.

**ESSENTIAL EPILEPSY.**—The *Phila. Med. Times* gives the following clinic by Prof. Pepper:

This little girl has been before you on one or two occasions. Let me recall to your minds the more important features in her history. She is ten years of age, born of healthy parents, with no inherited morbid tendency, and lives in a healthy

neighborhood. Up to the age of five years she was apparently healthy, but at this time it was noticed that she was "nervous" when her attention was strongly fixed. There is no history of severe sickness or other cause to account for this. Shortly after this it was noticed that the child began to have falling-spells, and these would sometimes recur as often as two or three times a day, and at no time did she go a week without an attack. In these seizures she would fall to the floor if there was no one at hand to support her, and she evidently lost consciousness for the moment, for she would assert that some one had thrown her down. There was no general convulsion, but for a few minutes there would be trembling of the hands. She did not froth at the mouth or roll the eyes, but after the attack had passed she became very red in the face.

She was brought to the hospital four months ago. At that time she was having the spells very frequently, and the mother could not trust her out of her sight. Her memory was also much impaired.

The story of this case is one of apparently essential epilepsy. No peripheral cause can be found for these attacks. The child has no heart-disease; there is no history of an injury or of a sudden shock of any kind, but gradually, without apparent cause, she at the age of five years began to have these attacks, which continued to increase in frequency until four months ago.

At that time, learning that the girl had been under the care of the family physician for some time, I concluded that the bromides had been thoroughly tried. The child was exceedingly feeble; she would drop down on the slightest exertion, and many of the falls were undoubtedly the result of muscular prostration and debility. There was also to a remarkable extent a want of mental activity. The child was listless, and her memory was rapidly failing. Concluding then that the bromides had been used, I considered it useless to push them. I thought it better to direct attention to hygiene, diet, the administration of tonic remedies, and trust to the development of the system, rather than attempt by specific remedies to coerce the manifestations of the disease.

I ordered a properly-regulated diet and the use of a simple solution of the phosphates of soda, lime and iron in an excess of dilute phosphoric acid. The child had no other treatment.

The mother reports that there has been decided improvement. The attacks do not recur so often, a week frequently intervening between the attacks. The disease is, however, far from being checked, but we are encouraged to persist in the plan of treatment adopted. In the meantime the child will be kept from school, the mother teaching her at home.

AN OLD FORM WHICH MIGHT WELL BE REVIVED, —To the kindness of Prof. Osler we owe the following copy of an indenture which was in use in the early part of the century in England, and which seems of sufficient interest to warrant publication. We commend it to the State Medical Society (*Med. Times*).

"*This Indenture Witnesseth*, That Edward O—, of the town of Falmouth, in the county of Cornwall, by and with the consent of his Father, doth put himself Apprentice to James X., of said town of Falmouth, Surgeon, to learn his Art and with him, after the manner of an Apprentice, to serve from the 2<sup>nd</sup> day of March, eighteen hundred and Eleven, the full End and term of five years from thence next following, to be fully complete and ended.

"*During* which term the said Apprentice his Master faithfully will serve, his secrets keep, his lawful commands everywhere gladly do. He shall do no damage to his said Master, nor see to be done of others, but to his Power shall let or forthwith give warning to his Master of the same. He shall not waste the Goods of his said Master, nor lend them unlawfully to any; he shall not commit fornication or contract Matrimony within the said term. He shall not play at Cards or Dice-Tables, or any other unlawful Games whereby his said Master may have any loss, with his own goods or others during the said term, without the license of his said Master. He shall neither buy nor sell; he shall not haunt Taverns nor Play-houses, nor absent himself from his said Master's Service day or night unlawfully, but in all things as a faithful apprentice he shall behave himself towards his said Master and all during the said term.

"And the said James X., for and in consideration of the sum of forty pounds lawful money of Great Britain, one moiety of which to him in hand paid, the other moiety when half the term is complete, the said Apprentice in the Art of Surgery and Physic which he useth by the best means that he can shall teach and instruct or cause to be taught and instructed, Finding unto the said Apprentice sufficient meat, drink, lodging, and all other necessaries during the said term.

"And for the true performance of all and every the said Covenants and Agreements, either of the said Parties bindeth himself to the Other by these Presents.

"In witness whereof, the parties above named to these Indentures interchangeably have put their hands and seals this 22<sup>d</sup> day of March, and in the fifty-first year of our Sovereign Lord George III., by the Grace of God of the United Kingdom of Great Britain and Ireland King, Defender of the Faith, and in the Year of our Lord one thousand eight hundred and eleven.

"Signed, sealed, and delivered in the presence of  
"I. GRIFFIN."

**CHRONIC ARTICULAR DISEASE.**—In the *LANCET*, Nov. 1884, p. 763, is published a lecture by Mr. Barwell, concerning the management of two principal forms of chronic articular disease; (1) that arising in the bone, and (2) that commencing in the synovial membrane. The author takes a case, in which he supposes that a certain portion of bone is enlarged, painful, and particularly sensitive to pressure; that the pain augments at night, and the limb starts violently just as the patient is falling to sleep, and the skin over the tender point of bone is red. These symptoms show that suppuration is imminent or has already commenced. This is the time for the surgeon to step in, and he should choose a point whence he could reach the bone without opening the synovial cavity; and here, pushing aside a little flap of soft parts, together with the easily detached periosteum, he may with a small trephine-head make an opening in the bone. While this is being done, he must observe what sort of fluid flows. If it be not pus, he must explore with a needle until pus is reached, or until it is certain no pus has formed. Pus, when present, should be detected and eliminated; but the treatment answers as well if pus have not already formed. After having established an opening, it should be kept open by means of a drainage-tube, so as to allow the cavity to heal with granulation from the bottom.

The author next goes on to the treatment of the sluggish form of synovial disease met with in strumous subjects, where there is a persistent tendency to the growth of flabby granulations which may ultimately undergo suppuration.

In these cases, the greatest value will be found in applying pressure to the affected part. This may be done by means of ordinary strapping, or by strapping one of the medicated plasters over the joint. The strapping should be often changed so as to make the pressure equable as well as persistent, and in many cases this is best attained by using a bandage of elastic webbing. If the swelling be large and soft, mere pressure is rarely sufficient; but the granulations must also be stimulated and this is effected by injecting among them a solution of some slight irritant. The best fluid to use is tincture of iodine, beginning with half a drachm to the ounce of distilled water, and increasing up to two drachms are generally sufficient, and this may be repeated once or twice a week. The limb must be placed in the most advantageous position, as a certain amount of stiffness is bound to follow; and great care must be taken to prevent as much as possible the limb from becoming fixed in any awkward position.—*The London Medical Record*.

**A CENTRAL TUMOR CAUSES JACKSONIAN EPILEPSY.**—Dr. William Osler, of the University of Pennsylvania, records in the January issue of *The American Journal of the Medical Sciences* the history of an instructive case of Jacksonian epilepsy,

the main points of difference between which and true epilepsy are the slow onset, local in character, beginning in (or in mild attacks confined to) one limb or a single group of muscles; the gradual extension until the side is involved, or in severe attacks the entire body; loss of consciousness late, not early and sudden as in true epilepsy; and, lastly, the muscular contractions are clonic.

His case lasted over fourteen years, the convulsions beginning in the left hand, at first monobrachial, then extending to the leg, afterwards becoming unilateral, and finally general; at first without loss of consciousness. For the first nine years of the illness there were remarkable intermissions, lasting for six or seven months, once for an entire year. Six years after the onset, the leg got weak and stiff. For four years, the tenth, eleventh, twelfth, and thirteenth years of the illness, the seizures were frequent. During this period there were six weeks of unconsciousness, in which spasms were very frequent, from fifty to eighty in the day. Ten months prior to the final attacks there was freedom from convulsions. The intellectual faculties were unimpaired.

The case was unusual in the limitation of the lesion to the ascending frontal convulsion and to its fasciculus of white matter, scarcely involving the grey substance, which is commonly affected in cortical epilepsy. The accurate localization and the remarkable absence of tissue-changes in the immediate vicinity give the case the nature of an exact physiological experiment. With this limited lesion of the motor area there was permanent paralysis with contracture of one extremity and epileptiform convulsions. Another feature of interest in the case is the light it throws on the situation of the leg-centre. The fibrous mass was situated entirely within the anterior part of the paracentral lobule, limited in extent, confined chiefly to the medullary fibres of the superior frontal fasciculus, and only touched the grey matter in places. A point to be referred to is the absence of the paralysis of the leg for the first six years; for if the convulsions and monoplegia were caused by the same lesion, how explain the late onset of the latter? From the fibroid state of the tumor it might reasonably be inferred that it was originally larger and had shrunk; but the absence of puckering on the surface, and the way in which the margins merged with the contiguous parts, make it probable that the growth was always small, so small in fact that at one period of its development it may have caused sufficient irritation to induce the convulsions, and yet at the same time not involve the special fasciculi of white fibres to the extent of producing weakness of the leg, or monoplegia.

**THE EXTERNAL USE OF CHLOROFORM IN LABOR.**—The *Chicago Medical Journal and Examiner* calls attention to a peculiar method of using

chloroform in labor, which originated, it is said, with Dr. A. Svanberg, of Sweden. This doctor claims to have found that, in severe cases of labor where rigidity of the os has caused an obstacle to delivery, the external use of chloroform is very advantageous. His method consists in applying a piece of flannel soaked in a mixture of chloroform and sweet-oil (one to one or two to one) to the abdomen between the symphysis and navel. Then by light strokes over the cloth he makes sure that it is close to the skin. In severe cases (after five minutes) he pours on more of the mixture. After from five to twenty minutes Dr. Svanberg always finds that the rigidity is so much lessened that any desired manipulations, such as turning, may be performed. Five cases are reported, illustrating the efficacy of this measure.

In December, 1877, he, with three other doctors, was called to a labor, in a primipara, rachitic, with small pelvis, transverse presentation, with arm protruding. The uterus was firmly contracted around the fœtus, and it was impossible to pass the hand into it, with the view of turning. She was completely anæsthetized, and continued thus for more than an hour without result. A warm bath was given, then again chloroform, but all in vain. At last he proposed to try chloroform externally, and in about fifteen minutes he could proceed with the turning.

This practice of applying chloroform externally in order to relax the parts and permit the introduction of the hand or instruments, is especially recommended to country doctors who have no assistant to give the anæsthetic by inhalation. It is not believed that it will succeed in very severe cases. It is probable that the patient practically gets a good deal of chloroform internally by this method.—*Med. Record.*

**INTRA-UTERINE MEDICATION.**—Dr. Lombe Atthill read a paper on this subject before the last meeting of the British Medical Association, and gave the following conclusions :

1. Carbolic acid in the proportion of one part of spirit to two of the acid, is the safest and most generally useful of all the agents employed.

2. Carbolic acid should always be applied by means of a probe, round the point of which a layer of cotton is rolled, the cotton being carried up to the fundus at least twice on each occasion that the applications are made, which should be on every third or fourth day, till marked improvement takes place.

3. Carbolic acid should never be injected into the uterus, except when combined with iodine, in the forms known as iodized phenol.

4. In many cases, iodized phenol may with advantage be applied by means of a probe.

5. In cases in which metrorrhagia or profuse menstruation occurs, depending on an unhealthy

condition of the intra-uterine mucous membrane, the cavity being dilated and the uterus enlarged, from half a drachm to a drachm of iodized phenol may be injected with great advantage.

6. In cases in which epithelioma attacks the mucous membrane of the cavity, the injection of iodized phenol promises better results than any other treatment.

7. The success likely to follow the injection of iodized phenol renders the dilatation of the uterus, the use of the curette, and the subsequent application of fuming nitric acid, less frequently necessary than has been the case hitherto.

8. The injection of iodized phenol requires to be carried out with so much care, that it should never be injected except by means of a syringe which will not contain more than one drachm.

9. The use of the fuming nitric acid should be limited, as a rule, to those cases in which dilatation has been practised, and it should always be applied through a tube, inserted into the cervix uteri for the purpose of protecting the sides of that canal from the action of the acid.

10. The pain produced by the application of any medical agent to the intra-uterine cavity, does not bear any relation to the activity of that agent, but is due to one of two causes—either to hyperæsthesia, or to narrowness of the cervical canal, especially of the os internum.

**MEDICAL FEES IN THE ARGENTINE REPUBLIC.**—A correspondent in the *British Medical Journal* (Jan. 10, 1884) gives the following as the scale of fees in the Argentine Republic:

"The ordinary charge for a consultation at a medical man's house is said to be two dollars (about 8s.); for a visit, four dollars, say 16s.; for attendance at confinement when all goes well, about £20; but when any special care or operation is required, these fees amount up to hundreds of pounds. Accounts for medical attendance are sent in and paid without remark, which would make the hair of a paterfamilias in the 'old country' stand on end. My friend mentions the following fees as having been lately obtained by doctors who, though of good standing, are not looked on as 'stars': For extraction of ovarian tumor, £1200; amputation of arm, principal, £600; amputation of arm, two assistants, each, £400; delivery with operation, £400; attendance during typhoid fever, £200; visit by a physician for dropsy, £50; consultation fees, £20 and upwards. Much depends, of course, on the position of the patient, but there are sufficient wealthy people to make up for any small fees or gratuitous work which may have to be done among the poorer classes.

"The statements given above are confirmed by another correspondent, who states that a friend of his paid £100 for attendance at the confinement of his wife, and adds that the charges by dentists



are on a like magnificent scale, as much as £5 or £6 being paid for stopping a tooth. There, however, appears to be one important condition: before a doctor is allowed to practice in the Argentine Republic, he must pass an examination, and be licensed by the Government Medical Board; and before he can do this he must, of course, be master of the Spanish language. The population of the country is so cosmopolitan, that the more modern languages he speaks, the better will be his chances for success."

**TREATMENT OF CHOLERA**—In view of the expected visit of the cholera to this country during the coming year, any contribution to medical literature, bearing upon the treatment of this disease, should receive careful and earnest consideration on a part of the medical profession. From the researches of Dr. Koch, it is now known that acids are most useful to kill the cholera microbe, and have been successfully employed by the profession in Europe.

Dr. Chas. Gatchell, of Chicago, in his "Treatment of Cholera," says: As it is known that the cholera microbe does not flourish in acid solutions, it would be well to slightly acidulate the drinking water. This may be done by adding to each glass of water half a teaspoonful of Horsford's Acid Phosphate. This will not only render the water of an acid reaction, but also render boiled water more agreeable to the taste. It may be sweetened if desired. The Acid Phosphate, taken as recommended, will also tend to invigorate the system and correct debility, thus giving increased power of resistance to disease. It is the acid of the system, a product of the gastric functions, and hence, will not create that disturbance likely to follow the use of mineral acids."

The following case is reported from Bangkok, Siam, and may be relied on as authentic: About three months ago a native was attacked with cholera. An American Missionary attended him, and administered all medicines he could, but at last the man was so far gone that they gave up all hopes of recovery, and would do no more. Relatives of the patient begging the doctor not to give him up as lost, the doctor thought of Horsford's Acid Phosphate. After the second dose the patient commenced to revive, and in six hours after, he was pronounced out of danger.

**DIFFICULTY OF DIAGNOSIS BETWEEN PLEURISY AND PNEUMONIA IN CHILDREN.**—Dr. J. Lewis Smith (*N. Y. Path. Society*) related the following case, and requested Dr. Northrup to give an account of the post mortem: An infant, aged eleven months, had for two months been ailing with whooping-cough. Ten days preceding the 24th of the month the bronchitis accompanying the whooping cough became aggravated. Then, in addition

to capillary bronchitis, there was an almost flat percussion sound over the right side of the chest except anteriorly, where the dulness was less marked. He supposed, therefore, that the child had pleurisy with effusion. The attending physician afterward aspirated the chest and failed to withdraw any fluid. Dr. Smith was obliged, then, to accept the probable diagnosis of pneumonia with thick fibrinous exudation over the lung. The difficulty often existed of distinguishing between pneumonia and pleurisy with effusion in children under fifteen months of age. In the present instance, as in many cases, no enlargement of the affected side could be noticed; not even bulging in the intercostal spaces.

Dr. Northrup then gave the results of the autopsy. The lungs were much more than usually compressed, and were slightly adherent anteriorly. In the pleural cavity was a pint of greenish-yellow fluid containing pus. The lung was so carnified that it scarcely rose to the surface of the water. Dr. Northrup said there were records of as many as from seventy-five to one hundred post-mortem examinations on the books of the asylum in which a mistake in diagnosis had been made between pleurisy and pneumonia in children.—*N. Y. Med. Journal*.

**PERMANENT CORROSIVE SUBLIMATE SOLUTION.**—Mr. Joseph Bulfin, in a note to the *Medical Times and Gazette* of November 1st, says: I have for some time been engaged in experiments and trials of various antiseptics, carbolic acid, eucalyptus, thymol, and iodoform, and since reading your article on Sir Joseph Lister's address, have made some on the following, which I think would be worth a trial. The modification which I would venture to propose is as follows: Corrosive sublimate, 3ij; white of egg, 3vj; Barff's boroglyceride, 3xii; distilled water, 3cxxxv. M. The strength of the corrosive sublimate in this solution will be nearly 1 to 500. As it would be almost impossible to add the precise quantity of albumen to render the bichloride of mercury unirritating and safe, it is desirable to add an excess of albumen; but an excess of albumen on the other hand, if allowed to decompose, would be objectionable in the extreme, to obviate which I suggest the introduction of boroglyceride which, without in any way interfering with the action of albumen, whether used from blood serum or white of egg, will guard against the products of decomposition from the use of an excessive amount. The proportion of mercury used in the compound may be increased or diminished as occasion may require, and all are non-volatile. Charpie, cotton-wool, or oakum saturated in such a solution would, in my opinion, form one of the best antiseptic dressings that I have yet seen, and for the chief part of this I am indebted to Sir Joseph Lister, my only contribution being the in-



production of boroglyceride.—*Med. Times and Gazette*, November 1, 1884.

**TENOTOMY OF THE LEVATOR PROSTATÆ IN ENLARGEMENT.**—Dr. Wyman in the *Medical Age* gives the following as his conclusions in regard to the treatment of enlarged prostate :—

1. The tendon of the levator ani muscle unites with the central tendon of the perineum, and invests the prostate gland in such a manner that when the prostate is enlarged, force is brought to bear upon it during efforts to evacuate the bladder, which rotates the prostate upon the urethra and shuts off the flow of urine.

2. A section of the perineum and its deep fascia and central tendon, will remove the force expended by the levator ani muscle in producing version of the prostate, and permit the muscles of the abdomen and bladder to evacuate the urine. Such a section implies tenotomy of what some anatomists call the *levator prostatæ* muscle.

3. An operation of this character involves a breaking up of the veins and lymph spaces on the rectal and lateral aspect of the prostate, and, if the wound is made to granulate from the bottom, atrophy of the prostate will follow, so that by the time the tendon of the levator prostatæ has reunited, no further difficulty in micturition will be likely to ensue.

**CHLORAL IN ALBUMINURIA.**—Burduzzi (*London Med. Record*) in 1878, noticed the good effect of chloral in albuminuria, recently confirmed by Dr. Wilson in the *Brit. Med. Jour.* His case in 1878 was that of a lady, suffering from insomnia in the last months of pregnancy, with dyspnoea, from general oedema of the legs and hands, and with highly albuminous urine, in which he ordered 2 grammes of chloral to be taken in two doses every evening. This treatment was continued for about twenty days with very good effects; sound restorative sleep was not only obtained, but the oedema disappeared, and the quantity of albumen in the urine was notably diminished. Labor followed in due course, and was in every respect normal, and the puerperium was free from any complication. Since then Burduzzi has always prescribed chloral in the last month of pregnancy, when there is much oedema, and the urine is scanty and albuminous, as a prophylactic against eclampsia. In a man, 45 years of age, affected by simple nephritis, chloral in doses of 3 grammes a day procured great relief in a short time, and the albumen almost entirely disappeared from the urine. In the so-called physiological albuminuria, chloral is also useful, as the author shows by the case of a man in whose urine albumen was almost constantly present. Burduzzi points out the need of more exact studies of the action of chloral on the renal tissue.—*Four. Am. Med. Association.*

**SALICYLIC ACID A CURE FOR TIC DOULEUREUX.**—We frequently meet in our practice cases of tic douloureux, that often so exceedingly painful neuralgia of the fifth nerve, where an operation seems to promise the only radical cure. If we hear of a remedy which is said to have the same effect as the surgical interference, we become doubtful; but if no less reliable authority than Prof. Nussbaum assures of the fact, our hope increases. Recently a number of such cases had been sent to N. for the purpose of having the operation performed, and, after a number of carefully-instituted experiments, this great surgeon recommends a trial with salicylic acid before proceeding to stretching or to resection of the nerve. In all the recently-sent cases he first tried this remedy, and he found it in every one a radical cure; not only a palliative effect, but really an utter disappearance of the painful disease, was the result in every case. Especially in cases of rheumatic nature, N. is positive of having discovered in salicylic acid a specific for tic douloureux. He administered the drug in the following manner: R.—Acidi salicylici, grs.  $3\frac{1}{3}$ ; sodii salicylatis, gr. 32; M. ft. pulv. Within 24 hours the patient takes from four to six of such powders.—*Med. and Surg. Reporter.*

**A PRACTICAL POINT IN THE TREATMENT OF PLEURAL EFFUSIONS.**—Dr. Broadbent (*Lancet*), in a clinical lecture, says that when he hears distinct bronchial breathing generally over the chest in cases of pleural effusion, he feels sure that a consolidated lung is immersed in the fluid, and he consequently does not tap unless the symptoms are so urgent as to demand interference. A solidified lung can not, of course, expand, as does one which is simply collapsed, or even compressed, unless it is bound down by adhesions; and experience has shown him that, on the resolution of the pneumonia, the fluid is usually rapidly absorbed.

He seems to hold the sound views that, with grave symptoms, a pleural effusion should be withdrawn, whatever the complication; that the course of moderate effusion may often be shortened by tapping; but that, if the lung be consolidated—one evidence of which is the persistence of bronchial respiration over the whole, or a large part, of the chest—it is better to wait, if the condition of the patient warrants such a course.—*Boston Med. and Surg. Journal.*

**CHLOROFORM IN LABOR.**—The subject of the use of chloroform during labor continues to give rise to diverse views on the part of obstetricians, though the great majority are on the side of its employment with certain limitations. One of the limitations is the prohibition of full anaesthesia, unless it be at the moment of delivery. Up to that time it is properly employed in small quantities merely to alleviate pain without producing un-

consciousness. We have no doubt of the entire safety of this plan. Nor do we doubt that it is preferable to ether for this purpose. There appears to be no danger from chloroform, at least when used in this mode, during the throes of labor. On the contrary, the condition of labor appears to exert a remarkable protective influence against chloroform accidents. In a recent discussion in the St. Louis Obstetrical Society reported in the *Courier of Medicine*, these views were sustained by the members. The following remarks by Dr. Papin on that occasion may prove interesting to our readers :

"I have used anæsthetics in labour very extensively. With Dr. Engleman, I play with chloroform in the first stage of labor; I become a little more earnest in the second stage; and when the child's head begins to come out, I give a full dose and produce anæsthesia."—*Pacific M. and S. Jour.*

**TREATMENT OF EPILEPSY.**—The *Fort Wayne Medical Journal* gives the following formulæ in epilepsy :

R Ammonia bromide. ....  
Elix. valerianate ammonia. aa  $\frac{3}{4}$  ij,  
Fl. ext. stramonium. ....  $\frac{3}{4}$  ij,  
Glycerine. ....  $\frac{3}{4}$  ij,  
Syrup auranti cort. ....  $\frac{3}{4}$  iv,  
Aqua dest. ....  $\frac{3}{4}$  v. M.

Sig.—Tablespoonful before meals. In addition to this take from grs. xxx to grs. lx of potassium bromide at bed time. Preface this treatment with an anthelmintic combined with an active cathartic and see that the bowels are subsequently kept in a soluble condition. The writer adds the prescription of a former colleague, which he endorses, not only in epilepsy, but many other diseases of the nervous system. He asserts that it will quiet the most excited lunatic :

R Bromide of sodium. ....  $\frac{3}{4}$  j,  
Bromide of zinc. .... grs. xxx ij,  
Glycerine. ....  $\frac{3}{4}$  j,  
Aqua cinnamomi. ....  $\frac{3}{4}$  vij. M.

Sig.—A tablespoonful three times a day in half a wineglass of water.

**PHOSPHATE OF SODA IN HEPATIC COLIC.** — Dr. Briston in the *Medical News*, says :—Apropos of the recent discussion in the New York Surgical Society, as published in your issue of January 31st, you are at liberty to publish the following notes of a case occurring in the rural districts :

Mrs. J., aged 28, was seen on the 22nd of October, 1884. Found her suffering intensely, the pain being referred to the region of the gall-bladder. The patient herself was firmly of opinion that she was suffering from gall-stone, and said her sister had suffered in the same way, discharging the stones a few days after the attack. This patient

further said that she had suffered with similar attacks at intervals for ten years. On the 23d of October, having relieved the suffering of the day before by morphia hypodermically, I put her upon drachm doses of the phosphate of soda three times a day. To quote her own expression, "the region of the liver felt as if it were being ground up." On the 25th, two days after, over one hundred gall-stones, varying in size from a duckshot to a large pea, were discharged per rectum. The present health of the woman is excellent, and she has had no further trouble. The phosphate of soda was continued for several weeks, but has been dispensed with now for two months. What one of the laboratory staff of the profession will give us, the *rationalité* of the action of this remedy in this class of cases, and also in catarrhal jaundice, for which it sometimes seems to act as a specific ?

**DRESSINGS FOR ULCERS OF THE LEG.**—B. F. Curtis, M.D., (*N. Y. Med. Journal*) states that in the out-patient department of the Chamber's Street Hospital, they have had good results from the treatment of ulcers of the leg with Lister's boric-acid dressing, applied with a crinoline bandage.

The leg and foot are thoroughly washed with a one-to-forty carbolic acid or one-to-one-thousand corrosive sublimate solution, and the ulcer itself is washed with a saturated solution of boric acid. Over the ulcer is put a thin gutta-percha tissue, which has been soaking in the boric acid solution, large enough to extend about one-fourth of an inch beyond its edges on all sides. The leg is wiped dry. Sufficient borated or salicylated cotton to take up the discharge is laid over the ulcer, and the rest of the leg from ankle to knee is wrapped with a half inch layer of cotton batting. An ordinary bandage is applied to the foot and from the ankle to the knee is applied a crinoline bandage which has been squeezed quite dry after soaking for five minutes in water. Care must be taken to have the cotton project beyond the upper and lower edges, as they may chafe the skin when dry and stiff. The crinoline will dry in half an hour; but if time is important an ordinary bandage may be applied over the crinoline and the patient be dismissed at once.

**PLASTER OF PARIS TREATMENT OF FRACTURES.** —Mr. Christopher Heath in *British Med. Journal*, endeavors to induce surgeons to have more faith in the early treatment of fractures by plaster of Paris than appears as yet at all general, and thus to save the patients and themselves an infinity of trouble. In his paper he quotes from "Aphorisms" of the late Dr. Cowling of Louisville, the following, which he regards as full of common sense :

"Carved and manufactured splints generally fit nobody, and are to be rejected, as not only expen-

sive, but damaging" "The application of the roller-bandage immediately to the skin, whether as a protective or to prevent muscular spasm, has resulted in such disaster, that it is one of the curiosities of surgery how it could be repeated at this day. When cotton is placed over such a bandage, it forms an absurdity scarcely credible in a man of common sense." "Continued extension, and counter-extension, are, as a rule, not necessary to prevent shortening in fractures. This is best done by removing the causes which lead to muscular spasm; 1st, by as early and complete reposition of the fragments as possible; 2d, by the smooth application of cotton-battling to the limb; 3d, by the equal pressure of a bandage extending from the distal end of the limb to a point beyond the joint above the fracture; 4th, by the accurate fitting of the splints or plastic material for support; 5th, by as little interference afterward as possible."—*Med. Record*.

**CROTON CHLORAL IN WHOOPING COUGH.**—Dr. W. C. Webb, of Bryantsville, Ky., (*Am. Practitioner*) says that he has employed croton chloral in whooping cough with more benefit than he found from almost any other remedy. This drug does not derange the digestive organs, nor effect the vital nervous centres. Patients frequently fall asleep on their chairs after using it. On taking this remedy the patient must be watched lest toxic symptoms be manifested. A child from one to two years old may take 1 grain of the preparation every four hours. One ten years old, may take 2 grains as often. After the first week the dose should be lessened and given at longer intervals. Should there be much gastric irritability, or should the paroxysm be very severe, a few whiffs of chloroform may be given in advance of the croton chloral. This may be repeated only three or four times.

The following formulæ are given for its administration: R. Croton chloral,  $\mathfrak{z}$ j; tinct. cardamon comp.; glycerine aa  $\mathfrak{z}$  ij. Sig.—One half teaspoonful every four hours for a child two years old and under; or, R. Croton chloral,  $\mathfrak{z}$ j; tinct. belladon., 5 ij; tinct. cardamon comp.,  $\mathfrak{z}$  ij; glycerine,  $\mathfrak{z}$  ij. M. Sig.—One-half teaspoonful.

**CAUSTICS IN ENLARGED TONSILS.**—Among various caustics for local use in causing shrinkage of tonsillar hypertrophies, Dr. Chisholm (*Virginia Medical Monthly*) has found the chloride of zinc the most available and the least annoying to the patient. He employs it in the following manner: A wire the size of a fine knitting needle, is roughened for a half inch from one end so that it may hold a fibre of absorbent cotton twisted upon it. Dip this into a saturated solution of chloride of zinc and thrust it to the very bottom of the crypt, and keep it there for several seconds. When withdrawn the whitened orifice marks the cauterization. By re-

newing the cotton for each follicle several may be thoroughly cauterized at the same sitting without causing any annoying irritation to the throat. A very few applications will cause the gland to shrink, as will be seen one week after the destructive cauterization has been made to the interior of the follicles.—*Medical Record*.

**SALICYLATE OF SODA IN RHEUMATISM.**—Prof. Clarke treated eleven cases of acute rheumatism—all that occurred in his ward at Bellevue—with this drug. In nine of the cases there was early improvement following the use of the medicine. In two cases the amelioration was more gradual. The influence of the medicine in "lowering the fever heat and diminishing the excited pulse were as marked as its power to relieve pain."

The formula used in all the cases is as follows:

R. Acid salicylic..... $\mathfrak{z}$  ij,  
Soda bicarbonat. .... $\mathfrak{z}$  ij,  
Glycer. e..... $\mathfrak{z}$  ss.  
Aq.....ad  $\mathfrak{z}$  viii. M.

Sig.—Tablespoonful every two hours the first day, and afterward the same dose, six times a day.

No unpleasant effect of any kind was noticed after the administration of the medicine.—*Medical Record*.

**FISSURE OF THE ANUS.**—Dr. Kelsey, (*New York Clin. Society*) stated that for the past two years he had not been obliged to stretch the sphincter for fissure of the anus, but had used instead a weak solution of nitrate of silver—never of more than five or ten grains to the ounce. In a recent case the patient was cured by a single application of a ten-grain solution, and in another and very severe and obstinate case a cure was effected in three weeks by this method.

Dr. Abbe has cured cases by the application of the solid stick. He thought the principle was simply to supply a coating of coagulated albumen.—*N. Y. Med. Journal*.

**PUERPERAL PERITONITIS.**—Dr. Garrigues, *New York Med. Journal*, speaking of the treatment of puerperal peritonitis says: At the beginning of the disease I wash out the uterus once thoroughly in order to remove what septic material might be found there. After this if there is any fetid discharge vaginal douches are used every three hours. Two large rubber ice-bags are placed on the abdomen and kept well provided with ice. But the chief remedy is opium. This is preferably given by the mouth, in one-eighth to one-fourth grain doses, frequently repeated so as to keep the patient free from pain. Brandy and whiskey are also used freely to counteract the effect of the ice and the opium. As to diet only milk and beef tea are given. The bowels are usually left undisturbed;

though at times it thought best an enema may be given.

**OPERATIVE TREATMENT IN INTESTINAL OBSTRUCTION.**—In the first Harveian Lecture (*Brit. Med. Jour.*), Mr. Thomas Bryant lays down the following rules for operative treatment :

1. Laparotomy should be undertaken as soon as the diagnosis of acute intestinal strangulation is made. There should be no delay allowed for the formation of a specific diagnosis of its cause. It should likewise be proposed in all cases of acute intussusception, and of chronic, which have failed within three, or, at the most, four days, to be relieved by other treatment.

2. In all operations of laparotomy, it is to the cæcum that the surgeon should first advance, since it is from it he will obtain his best guide. If this be distended, he will at once know that the cause of obstruction is below ; if it be found collapsed, or not tense, the obstruction must be above. Adhesions or bands are, moreover, more frequently near to, or associated with the cæcum, than with any other part of the intestinal tract. It is also in the right iliac fossa that the collapsed small intestine, in cases of acute strangulation, is usually to be found ; and, with this as a starting-point, the surgeon will have less difficulty in tracing up the intestine to the seat of strangulation than if he begins at a distended coil, when it will be a matter of chance whether he travels away from or toward the special object of his search—the seat of obstruction.

3. In a laparotomy, when the strangulated coil of bowel is gangrenous, it should be brought out of the wound, and the gangrenous knuckle resected. The proximal and distal ends of the resected bowel should then be stitched to the edges of the wound, and an artificial anus established.

4. Nélaton's operation of enterotomy should be undertaken in all cases of intestinal strangulation, when laparotomy is rejected or seems inapplicable, as well as in cases of intussusception in which the invaginated bowel cannot readily be released. It should be performed in the right groin, or, rather, right iliac fossa.

5. If laparotomy succeed, the cause which called for it is removed, and the normal action of the bowel is restored. If resorted to early, and as a rule of practice, it is probable that it would be more successful than the treatment by opium, inflation, or purgatives, which has hitherto been in vogue.—*Med. and Surg. Reporter.*

**TELESCOPIC CATHETERIZATION.**—Dr. A. E. Dugas, of Augusta, Ga., sends us an account of a method employed by him in cases of retention from so-called impermeable stricture of the urethra. He takes the largest sized gum-elastic catheter which will enter the meatus, passing it down until

arrested at the narrowed portion of the urethra. It is then withdrawn cut off just above the eye, the edges smoothed off, and then reinserted. When it has passed as far as it will go the end is cut off about an inch from the meatus, and the rest of the tube tied so as to prevent slipping from the canal. Now another catheter is chosen of a size that will just pass through the one *in situ*, and is inserted as far as it will go. It will probably pass farther than the first one, but if not, a smaller size must be selected. If this do not enter the bladder it is to be passed as far as possible and then the eye cut off as in the first case. Now a third catheter passed through number two will almost surely enter the bladder, except in the very worst cases. The larger or outer instruments serve, Dr. Dugas states, not only to ward off and exhaust the contractions of the urethra, but also to act as a stiff handle to direct and guide the smaller and more flexible instruments passing through them.

In connection with this subject the writer states his belief that a great many more cases of retention of urine are due to some derangement of the kidneys than to the urethra. And he says that he has "frequently relieved such cases like magic by a dose of nitrate of potassa, say ten or fifteen grains, twice a day or oftener. The trouble is not that there is too much water in the bladder, but that what water is there is very irritating, and the urethra being more or less strictured revolts against its passage."—*Med. Record.*

**RADICAL CURE OF HERNIA.**—In one of the latest attempts to effect by operation the radical cure of hernia the "invagination" method has been neglected in favor of procedures aiming either at obliteration of the whole sac or simply at direct closing of its neck. A portion of Sir William MacCormac's surgical address at the meeting of the Association at Belfast was devoted to this subject, and several cases were recorded therein of successful excision of the sac. Professor Stokes advocates an operation consisting in the insertion through the incised neck of the sac, near to the external ring, of one or more catgut sutures, and the subsequent approximation of the pillars of the ring by sutures of stronger and more durable material. Mr. Barton of Dublin, cuts down on the neck of the sac, and brings the pillars of the ring together by strong silver wire, which he allows to remain. Torsion of the sac is recommended by Mr. Ball, of Dublin, who, in a paper read before the Section on Surgery at Belfast, gave details of a case in which, after having exposed the neck of a large scrotal tumor, and separated it from the cord, he twisted this portion of the neck with some force.—*Brit. Med. Journal.*

**TREATMENT OF BURNS BY BORACIC ACID OIL.**—C. J. Bond, F.R.C.S., (*Brit. Med. Journal*) writes as follows : It is now a year since we began

to use boracic acid oil as a dressing for burns at the Leicester Infirmary, at first simply in the form of a mechanical suspension of the powdered acid in olive oil. I have found that 18 grains of powdered boracic acid dissolved in a drachm of hot glycerine, and added to an ounce of olive oil, forms a kind of imperfect emulsion, the glycerine retaining the acid in solution when cold. This can be easily shaken up with oil. This makes a non-irritating and doubly antiseptic dressing, and extensive burns treated thus, and covered with a layer of some antiseptic wool, require to be disturbed but seldom, and if not perfectly aseptic, are far "sweeter" than when dressed with, for instance, the carron oil. As a lubricant for catheters, sounds, etc., this boracic oil with glycerine possesses advantages. It is superior to olive oil because of its antiseptic property; and better than carbolic oil, because it is less irritating and much more stable, boracic acid being non-volatile. Glycerine itself, too, is a dressing of considerable value by virtue of its dehydrating power.

**PRURITUS VULVÆ.**—There is probably no complication of pregnancy which so much annoys the woman as pruritus of the vulva. So persistent is it at times as to even cause serious mental depression, and the remedy which shall promptly relieve it is a great boon. Dr. Atthill, of Dublin, recommends the following lotion:

R. Acid carbolicæ, gr. xx.  
Tr. opii, ʒ ss.  
Acid hydrocyanici dil., ʒ ij.  
Glycerini, ʒ ss.  
Aquam q. s. ad., ʒ iv.—M.

Sig.

This is to be applied to the parts by means of a pledget of cotton thoroughly saturated with it and left in contact with the parts. The same lotion, similarly applied, is said to be also useful in pruritus ani.

We have found the application of essence of peppermint to be an efficient remedy. It must be carefully and gently applied at first, and if the smarting which it causes be very severe it may be diluted with an equal quantity of alcohol.

The British Medical Journal alludes to the use of balsam of Peru in this connection as a new triumph in medicine. We had occasion recently to apply it in a case of intolerable pruritus of the vulva, in a woman in the seventh month of pregnancy. The effect was exceedingly satisfactory. It is said to be equally efficacious when the anus is similarly affected. A pledget of cotton is saturated with it and allowed to remain in contact with the parts.

A physician with whom we recently conversed on this subject, declared a saturated solution of borax in laudanum, to be an infallible application, in his experience.—*Medical Age.*

**DISPENSARY ADVANTAGES IN PHILADELPHIA.**—The dispensary advantages are so extensive in this city, that the poorer and sometimes even the middle classes are enabled to get good medical and surgical advice without pay. Since the two institutions for advanced medical learning have been established, there is not clinical matter to go around. It is now no uncommon matter to find "interesting cases" hiring themselves out at rental ranging anywhere from twenty-five cents to two dollars per lecture, and if this goes on, the possessor of a well marked case, say, for example of lupus, may regard his face as his fortune.—*Phila. Med. Times.*

**AN EXCELLENT COUNTER-IRRITANT.**—Dr. Ellwood gives the following in the *New England Med. Monthly*: Some years ago I saw the following counter-irritant in one of the medical journals (which one I now forget), and which in certain classes of cases I have found very beneficial:

R. Oleum Tiglii.....ʒj  
Ether Sulph.....ʒij  
Tr. Iodine.....ʒv—M.

S.

This excellent counter-irritant is applicable where it is not necessary to produce too much effect. It is particularly nice for children.

**REMOVING A CINDER FROM THE EYE.**—Dr. Deming in the *New England Monthly* says: Recently while riding in the cars, I was unfortunate enough to get a cinder in my eye. After vainly trying to extract it myself I went up to one of the brakemen and asked him if he could remove it for me. He lifted the lid and catching sight of the little foreign body, he said very quickly, "O yes!" and pulling from his head a long hair he made a loop of it and passing it over the conjunctiva, quickly removed the particle. The manoeuvre was so simple and successful and to me new, that I thought it worth sending to your monthly.

**SURGICAL FEVER.**—The *Coll. and Clin. Record* gives the following as a mixture used in surgical fever, at Jefferson College Hospital:

R. Liq. ammon. acetat.,  
Liq. potass. citrat., aa ʒj,  
Spirit. æth. nit.,  
Liq. morph. sulph., aa ʒss.—M.

Sig.—Dessertspoonful ter die.

If the fever runs very high, grt. ij tinct. aconit. rad. are added to each dose.

**OSMIC ACID IN SCIATICA.**—Osmic acid is recommended by James Mercet, M. R. C. S., in the *Lancet*, for sciatica. From three to five minims of a one-per-cent solution is injected by the hypodermic syringe deeply into the parts over the course

of the nerve midway between the tuber ischii and the trochanter major. There may be slight numbness following. In some the effect was marvellous. Out of eighteen cases twelve were given relief for several weeks, when they passed from under observation.

**THE TREATMENT OF SICK-HEADACHE.**—Dr. W. Gill Wylie, of New York, has produced excellent results with the following method of treatment: So soon as the first pain is felt, the patient is to take a pill, or capsule, containing one grain of inspissated ox-gall and one drop of oil of gaultheria, every hour until relief is felt, or until six have been taken. Dr. Wylie states that sick-headache as such is almost invariably cut short by this plan, although some pain of a neuralgic character remains in a few cases.—*N. Y. Med. Journal*.

**REPETITION OF IODINE INJECTIONS IN HYDROCELE.**—Professor Tillaux drew the attention of his class, at the Beaujon, to the danger of being in too great a hurry in repeating injections of iodine in hydrocele. It is only at the end of six weeks or two months that we can judge of the result of the first injection, and to interfere before this time is to expose oneself to induce the formation in the tunica vaginalis of those false membranes which are so vascular that they bleed on the slightest shock, and thus give rise to hæmatocele and the loss of the testicle.—*Med. and Surg. Reporter*.

**CRYSTAL PEPSIN.**—The surgical value of pepsin as a dissolvent is well shown in a note in the *North-Western Lancet*. The editor of that journal states that he was once called upon to relieve the distress occasioned by a bladder distended with clotted blood. He injected a scruple of Jensen's crystal pepsin in an ounce of warm water, and had the satisfaction of seeing the patient pass a full stream of urine and disintegrated blood, in less than twenty minutes.—*Med. and Surg. Reporter*.

**THE RELATIONS BETWEEN PHYSICIAN AND PATIENT.**—A recent number of the *Lancet* contains a thoughtful editorial upon this subject, called out by an unjust charge against a medical gentleman. The subject is a delicate one, but the writer has approached it in a most careful and unobjectionable manner. It is not wholly unnecessary to remind physicians that they never can be too cautious in dealing with a certain class of women, who maliciously involve an innocent man in lasting disgrace. The recklessness with which some of the younger men allow themselves to treat pelvic diseases, without providing the smallest loop-hole for escape in case of unjust accusations, is a constant matter of surprise to those who have learned caution from experience. Short visits, entire absence of familiarity, and a refusal to undertake any pro-

cedure in a questionable case without the presence (or knowledge) of a third party—these are the only safeguards. "It is usually advisable to avoid mixing social with professional visits," says the article to which we allude; "a doctor visiting *as a doctor* should play the doctor and not the visitor; he may visit *as a visitor* at another time. In cases of domestic unhappiness or separation he should be doubly cautious."

Enough has been quoted to show the tenor of the remarks. No man who follows out these precepts can fail to conduct himself on every occasion in a manner worthy of the honor and dignity of his profession.—*N. Y. Med. Four*.

**OAKUM AS A SURGICAL DRESSING.**—By Robert Leslie, M.D., Belfast (*Brit. Med. Journal*).—Oakum is made from old ship's rigging which has been soaked in tar, and then reduced to its original state of flax or hemp. During the American war oakum was extensively employed in the field hospital as a surgical dressing.

Eight years ago I commenced to use this dressing in the Children's Hospital. Since that time oakum has been in use in all the hospitals of Belfast, and by some is now considered indispensable. I have been using oakum for burns, erysipelas, ulcers, abscesses, and many vaginal displacements; and I think it the best ready-made dressing we possess. One of its advantages is that it keeps down offensive odors. The serum from a wound is drained as it is discharged, and pleasant tarry smell is a great contrast to the offensive odor common in connection with lint.

In amputation it forms a soft and comfortable pad for the stump, and is a good vehicle for the application of antiseptics. In the treatment of abscesses it takes the place of a poultice by dipping it in warm water and covering with waterproof tissue. Its application, after opening an abscess, permits the easy escape of pus, and is conducive to quick healing. In erysipelas I envelope the affected part in oakum, and with such good result that I do not seek another agent.

As to dressing for burns and scalds I look upon oakum as invaluable. It may generally be applied to the granulating surfaces with impunity, and is more easily detached than almost any other dressing. I thus account for the fact: when a dry fibre of cotton is placed beside a fibre of linen under the microscope, you perceive that the cotton is round and smooth while the linen is sharp and angular but on the application of water the case is different. The cotton fibre is found to twist in a spiral manner, while the linen fibre is unmoved. It is a popular theory that cotton does not form so good a dressing as linen, and this hygroscopic difference may account to a great extent for their difference in behaviour when applied to moist surfaces, and the ease in removing linen.

In uterine and vaginal affections oakum can be turned to good account. The healthy effect of this tarry substance applied to the mucous membrane of the vagina is most remarkable. A tonic effect is produced, and the unhealthy discharge is absorbed. In prolapse and other displacements of the uterus when it is difficult or impossible to get pessaries to relieve, you can secure twenty-four hours' respite to your woman by filling the vagina with oakum, and by dipping the first plug in glycerine you gain immensely in cases of subinvolution from the quantity of fluid extracted.

To sum up: oakum is a handy, healthy, and cheap dressing. It is easy to apply, and I think it is antiseptic in the sense of forming a barrier to the ingress of germs to the part to which it is applied. Tar is itself a wholesale agent, a substance of complex composition. It contains creasote, turpentine, paraffin and eupione, and is obtained by the destructive distillation of *pinus sylvestris*. Carbolic acid has largely taken the place of the cruder compound, but Dr. Whittle says the virtues possessed by tar are not equally enjoyed by its more fashionable rivals. In oakum we have a form of tar dressing which I recommend to those engaged in hospital work.

**NEW MODE OF LOCALIZING BULLETS.**—In the transactions of the Vt. Med. Soc., Dr. S. J. Allen says:

"Perhaps I may be pardoned if I say, that during the four years of the war I served in the field one year as surgeon of a regiment, two years as Surgeon-in-Chief of a division, and last year as Medical Inspector of the Sixth Corps, and must have seen and examined, if not treated, many gunshot wounds. In all I have examined, be they more or less in number, I never localized a dozen bullets with a probe.

"In nearly all not localized by the finger or sense of touch, I succeeded in fixing with certainty their exact location by the use of the exploring needle.

"I claim that if the bullet did not enter either of the cavities of the body, but lays anywhere in the periphery among the muscles, or other tissues exterior to them, the exploring needle, in the hands of the surgeon, will, by puncturing a reasonable number of times, hit the ball, and convey the intelligence of its exact location.

"Had the exploring needle been used in the case of our late President, the 'encysted wall of pus in the right iliac region' would have been punctured without appreciable resistance, and his surgeon saved the Blissful diagnostic error contained in several of their bulletins, which located the fatal bullet at that exact point with absolute certainty.

"A serviceable instrument for this purpose will be found in the smallest sized exploring needle,

with which, all will admit, it is quite safe and comparatively painless to make the puncture.

"It is not unusual to puncture not only the peritoneal cavity, the pleural cavity, and the bladder, but the intestines, and the pericardium, and seldom has harm resulted.

"The probe should be used only to determine the direction the ball took from its point of entrance, and to ascertain if it entered a cavity. Here, I claim, its usefulness ends, and if further used does harm.

"The surgeon almost always has an impression, after an examination, that the ball lies at a certain point. To test this impression, push the exploring needle from the surface directly down to this point. If it does not hit the resisting bullet, try at the next most likely point. If not successful try again. The bullet can be localized in this way many times where all other methods fail. When the needle hits the ball, the surgeon will make the counter incision for its extraction with perfect confidence.

"Supposing that the bullet lies in close proximity to a bone, or is flattened upon a bone, by using a little more force, the point of the needle will be made to penetrate the ball slightly, and will stick a little, and thus convey to the surgeon's hand a sensible difference between bone and lead."—*Med. and Surg. Reporter*.

**A POINT IN THE EARLY DIAGNOSIS OF PREGNANCY.**—The *Medical Chronicle* quotes from a paper published by Hegar, in the *Prager med. Wochenschrift*, to the effect that this writer has noticed what he considers an important early sign of pregnancy. Hegar calls attention to the fact that during pregnancy the lower uterine segment becomes thinner and softer than in the non-gravid organ. This condition can be made out easily by bimanual palpation, especially if one finger is placed in the rectum while the uterus is depressed from above with the other hand. The sign is said to be nearly constant, but its absence is by no means a proof that pregnancy does not exist.—*N. Y. Med. Jour.*

**NEUTRAL MIXTURE FOR FEVERS.**—Prof. Brinton speaks highly of the following neutral mixture in fevers of moderate type. R. Liquor ammonii acetatis, ʒj.; liquor potass citratis, ʒj.; spiritus ætheris nitrosi, ʒss.; liquor morph sulphatis, ʒ ss. M. Sig. Two teaspoonfuls three or four times a day. If the fever is of a higher type, and the pulse full and bounding, tinctura aconiti radices ℥ii.—xxiv. may be added to the mixture with advantage.—*Med. Bulletin*.

**ERGOT IN CONSTIPATION.**—In the *Allgemeine Med. Zeitung* (Medical Press), Dr. Granze reports two cases of constipation following the abuse of purgatives cured by ergot. Three doses of ten grains



each were given at intervals of two hours and were followed by copious evacuation. A second stool occurred spontaneously the next day, and after the administration of ergot in small doses for a few days a definite cure was obtained. The constipation was due to atony of the muscular wall of the intestines.—*Louisville Med. News.*

**LINIMENT FOR RHEUMATISM.**—The *Therap. Review* says: Methyl salicylate (oil of wintergreen) mixed with an equal quantity of olive oil or linimentum saponis, applied externally to affected parts in rheumatism, affords instant relief, and having a pleasant odor, is very agreeable.

Dr. A. L. Loomis says: "A man can take two or three glasses of stimulants through the day as he may feel the inclination, and he may continue this habit for perhaps 25 years without any evident harm accruing from it; but when this man reaches that period of life when the vital powers are on the decline he suddenly finds himself old before his time, for he has all these years been laying the foundation for chronic endoarteritis. I believe, gentlemen, that 50-per-cent of all diseases arise from the use of alcoholic stimulants.

Erichsen says: "The practice of operating in notoriously hopeless cases with a view of giving the patient what is called 'a last chance' is much to be deprecated and should never be followed. It is by operating under such circumstances, especially in cancerous diseases, that much discredit has resulted to surgery; for in a great number of cases the patient's death has been hastened by the procedure which instead of giving him a last chance, causes him only to be despatched sooner than he otherwise would have been."

There are four plans for reducing obesity. 1. The eating of nothing containing starch, sugar or fat, called the Banting system. 2. The eating of fat but not sugar or starch, called the German Banting. 3. The clothing in wool and sleeping in flannel blankets instead of sheets, the Munich system. 4. Not eating and drinking at the same time, or rather with a couple of hours between the eating and the drinking, the Schwenger system.—*Detroit Lancet.*

The oldest physician in the world, Dr. C. C. Graham, died at his home, in Louisville, on Tuesday, the 3rd inst. He celebrated his one hundredth birthday on the 10th of October, 1884. He was the last link which bound the pioneers of Kentucky to the present generation. A man of remarkable physical and mental power, he practiced his profession for a period equal to the lifetime of the average physician, and spent his old age in scientific and literary pursuits.

Chloral hydrate is recommended as a substitute for cantharides, as a vesicant. Sprinkle powdered chloral on ordinary adhesive plaster, melt it with a gentle heat and apply to the part. In ten minutes vesication will be complete. Its advantages are rapidity of action, less pain, freedom from danger of absorption of cantharidin, and the plaster may remain on until the sore is healed.

**PAPINE.**—Dr. F. O. Young, of Lexington, Ky., says; I have used Papine in my practice and have taken considerable pains to test it and watch its action. I think it superior to any preparation I ever saw used containing opium. It is safe and pleasant and in no case did it ever produce the least nausea.

Dr. James E. Baker (*Med. Record*) recommends cocaine in phthisical cough. Five minims of a four per cent. solution, with a like amount of chloroform, are dropped upon an inhaler and taken at bed time. In two cases of this kind he succeeded in giving the patients a better night and making them more comfortable than he had been able to do by any other mode of treatment.

Dr. Forrest in the *Medical News* reports excellent results in a severe case of dysmenorrhea from the hypodermic administration of five minims of a 4 per cent. solution of cocaine. Complete relief was afforded for five hours, and comfort for a much longer time.

—Syphilitic condylomata dwindle away visibly on application three times a day of the following powder dusted over the new growths:

R.	Hydrarg. subchloridi,	- -	gr. xxx.
	Acid. Boracic,	- - -	gr. xv.
	Acid. Salicyl,	- - - -	gr. v.

Chloral hydrate is said by Dr. Roberts Bartholow to be the incomparable remedy for cholera. In many cases of cholera infantum it certainly is of great service.

Dr. F. N. Otis (*Med. Record*), says that he has recently given for three months twelve drachms of the iodide of potassium every twenty-four hours to a patient suffering from syphilis. Entire relief followed from all dangerous symptoms.—*Detroit Lancet.*

To remove foreign bodies from the ear Mr. Jonathan Hutchison recommends the introduction into the ear of a loop of small flexible silver wire. This being hooked about the foreign body, permits of its ready extraction.—*Detroit Lancet.*

# THE CANADA LANCET.

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## THE TREATMENT OF ASTHMA.

The ordinary physician is prone to regard chronic disease as a thing to be endured rather than cured. Especially is this true in the case of asthma. Why the case of the unfortunate asthmatic should be passed over more lightly than that of sufferers from other chronic diseases, finds an explanation in the notoriously unsatisfactory results of treatment, and the patient's almost certain tenure of life, for the time at least, despite his suffering. When, however, we reflect on the number of asthmatics, and the misery they endure, such indifference is both irrational and cruel. We desire, therefore, to call attention to the nature of the disease, the misery it entails, and the ineffectiveness of common routine treatment, in the hope of stimulating a spirit of more exact enquiry, both as regards etiology and treatment.

Research, and the application of remedies, in any certain direction, usually bear some relation to the importance of the disease undergoing investigation. Here is a disease which afflicts, more or less seriously, millions of the human family, causing much bodily and mental suffering, incapacitating for work or business, and shortening life, yet the physician with all his boasted knowledge has to confess that he is almost powerless to cure, and, at best, only hopes to afford his patient transient relief. We all know how true this is, and how disheartening to the sufferer. He who suffers from chronic consumption, chronic bronchitis, inveter-

ate skin disease, or other troubles equally obstinate, receives more encouragement and comfort at the hands of science than the poor asthmatic. This is all the more strange when we consider that idiopathic asthma is not marked by structural change. This of itself, of course, amounts to nothing, as what at first sight appears simple and easy of accomplishment, on closer examination, may turn out complex and difficult to conquer. Nevertheless it is almost certain the asthmatic has received but scant justice at the hands of the profession. His case has not been examined with due care—causes, immediate and remote, have not been closely inquired into, and he has been altogether too hastily consigned to the limbo of incurables.

It is not sufficient to know that our patient is suffering from asthma. Before we ever attempt to cure him, or afford him transient relief, some important enquiries are essential. This will appear all the more necessary when we remember that the disease is seldom truly idiopathic, but is generally associated with, or dependent upon some other trouble. True, the vast majority of cases may be relieved off-hand, for the time, by one or more of the stock prescriptions for asthma, without any close scrutiny of the case. It is just here where the common error in the treatment of asthma begins. If the attack be the first, or the disease have not yet so far advanced as to have ingrained itself, so to speak, into the patient's constitution, the more culpable is such hap-hazard treatment, since a clear apprehension of the case at the outset might have led to a different and more successful course of treatment. *Cure*, and not temporary relief, should be our aim in all recent cases, especially in the young. To say that asthma is incurable is to utter an absurdity. Some cases are cured spontaneously; some by physiological changes in the constitution; others by a change of residence, and, we hope, not a few, by medical treatment. There can be no doubt, however, that the great majority of chronic cases are incurable, and that the best we can do has no lasting beneficial effect. But even here it is proper to discriminate in order to a choice of remedies in individual cases.

Asthma essentially consists in a spasm of the bronchial muscles which surround the smaller air tubes, with simultaneous congestion of the bronchial mucous membrane. The asthmatic will te

us that his difficulty lies not so much in his inability to take in air, as to expel it. Asthma is sometimes secondary to bronchitis—hence some writers divide spasmodic asthma into two divisions, *idiopathic* and *bronchitic*. A broader division is indicated by *idiopathic* and *symptomatic*. To be able to class any individual case in one or other of these divisions will afford some definite data for treatment. The purely spasmodic case, if such there be, will require management differing from that classed as bronchitic or symptomatic, and *vice versa*. Sight should never be lost of the fact that asthma is often the result of reflex action, the seat of origin being the brain, lungs, stomach, or other organ, frequently requiring for its location much patience and skill. From these observations it will be seen that the proper diagnosis and treatment of asthma is not by any means so light a task as many seem to think. The observance of these, and other points that will readily occur to the thoughtful practitioner, would do a good deal towards lifting the treatment of asthma out of the domain of empiricism, which has always been its bane, to a basis as rational and scientific as that on which rests the treatment of many other disorders.

As to the remedies recommended in the books for this disease there is no end. With no intention of depreciating the value of several old and well tried remedies, we shall now only refer to agents which have recently forced themselves to the foreground. Of these perhaps citrate of caffeine stands first. The dose is one to five grains, dissolved in warm water. It does not appear to be a very dangerous agent, since, in one instance, a patient took 60 grains by mistake, without fatal consequences. Caffeine is said to afford very prompt relief. Arsenic, in the form of 2 or 3 minims of Fowler's solution is reported as making striking cures in appropriate cases. Arsenic has the peculiar property of supporting respiration, as, for example, in making ascents. Its beneficial effect in asthma is no doubt due to this property. Iodide of potassium, is sometimes combined with Fowler's Solution. A valuable combination in the bronchitic form is iodide of potassium, and carbonate of ammonia. Chloral hydrate, either alone or in combination with bromide of potassium, is also followed with excellent results in certain cases. In the form of stagnant respiration with congested

lips and nose, and cold extremities, strychnia has been found highly useful. The liquor may be given in doses of from 3 to 5 drops with dilute phosphoric acid. When defluxion from the mucous surface is very profuse, belladonna probably answers best. Medium doses should be given every 4 hours. Grindelia robusta a short time ago was largely used; but failed to come up to expectations, and is now much less used. Quebracho is also a remedy in much repute. We occasionally meet cases of continued distress despite the use of ordinary means. In these cases there is usually much bronchial tumefaction and dryness. In cases of this class nothing can equal one-fourth grain of pilocarpine, with one-fourth grain of morphine, administered hypodermically. The relief is prompt, the tumefaction subsides, and is followed by profuse expectoration. As to change of climate, experience shows that the asthmatic should not seek a dry atmosphere, such as that of Colorado, and the West generally. On the contrary, a warm, moist atmosphere is the most suitable. In mild cases a mere change from one locality to another may create immunity from this harrassing trouble.

#### THE PREVENTION OF CHOLERA.

With the advent of Spring and summer, the invasion of cholera may be looked upon as one of the probabilities, and therefore the authorities should set about preparations as actively as possible for its prevention. There may be still some doubting Thomases who cannot believe that sanitary measures are of any avail to protect the people from these so-called visitations of Providence. We trust however, that the authorities will not be influenced by any such foolish notions, but will put into vigorous action all the sanitary resources of the country, with the view of stamping out the first approach of cholera to our shores.

If anything were wanting to show the great value of sanitary measures in stamping out this scourge, it will be found in the experience of the city of Genoa, during the prevalence of cholera in France and Italy. The United States consul at Genoa in a communication to the Home Government on this subject, gives the methods adopted there from which are transcribed the following:

He says: "Since the outbreak of cholera at Toulon and Marseilles a continual purification of

streets, alleys, private and public houses, has been kept up, the most powerful disinfectants being used for the purpose, which made the city all summer, as it is to day, one grand smelling-bottle, of sulphur, chlorine, etc. Impure water, or water supposed to be impure, was shut off from the city; stale fruits and vegetables were seized and destroyed; this year's wine crop was not allowed to be brought into Genoa, and all the wine shops were forced to be closed at 8 p. m., daily. The rules were rigid in regard to household cleanliness, and the use of disinfectants in whitewash, and if the owner of an establishment of any size heeded not the orders of those in authority the work would still be performed, and at the expense of the proprietor. In three hundred cases of cholera before the Aqueduct Nicolas was shut off from the city, there were two hundred and seventy-five deaths, and all the victims had been using this water. Since the water was shut off from the city, the cases were few among those who could obtain good wholesome food. The Sunday excesses among the laboring classes proved a powerful feeder of the epidemic. From this fact it appears that regular habits of work or play are essential in avoiding cholera. The doctors all said that substantial food proved a better means of battling with cholera than doctors' medicines."

The Consul seems especially to consider that above all things pure water is essential in the battle with the enemy. In this contention he will be sustained by all who have given any attention to the subject. In his concluding remarks he says:

"Let a city or town have officials who energetically and fearlessly fight everything which has a tendency to prey upon public health, granted the people abuse not nature; let substantial food be one's daily portion; to these things add a frame of mind prepared to face calmly and bravely whatever trials and vicissitudes may cross one's path, and you have an armor that will, I am positive, in nine hundred and ninety-nine cases in a thousand baffle the type of cholera which has lately raged in Genoa."

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#### MEDICAL HEALTH OFFICERS.

The position of medical health officer of a large city is one of great responsibility and requires the

possession of the highest qualities in the individual who accepts it. The incumbent must be a man of good tact and judgment, skilled in his profession, and well versed in sanitary science. Such men are rarely available, especially in view of the miserable salary usually paid such officers in this country. In this city for example, with a population of one hundred thousand, covering an extensive area, with unsanitary conditions in abundance, and sufficient work to keep a medical officer constantly employed, the incumbent (Dr. Canniff) a gentleman eminently qualified for the discharge of the duties appertaining to the office, receives the paltry sum of \$1500 per annum for his services, from the city council, and even this small amount is given grudgingly. A supplementary sum of about \$600 per annum is also received by him from the Dominion Government for extra work in the compiling of Vital Statistics; but certain members of the council, with a niggardliness which is characteristic, propose to deduct the amount received from the Dominion Government, from the sum which was agreed upon as his salary (viz. \$1500). These gentlemen might with the same propriety deduct from his regular salary the amount received by the city clerk for similar work done for the Ontario Government.

We hope and trust that this has not been the the experience of health officers in other cities, for if such is the case we pity them. The gentlemen who have abandoned their private practice to engage in the important and onerous duties of medical health officers, in our large cities, deserve better treatment at the hands of the civic authorities. The services of the medical profession when required must be estimated at their proper value, and the sooner the civic authorities recognize this fact the better it will be for all concerned. No medical practitioner with the proper qualifications for so important an office should be expected to perform duties which require the whole of his time, without receiving at the very least a salary of \$2500 per annum. The recent changes in the Ontario Board of Health entail considerable extra work upon the health officer, and the entire duties appertaining to the office demand the whole of his time. He should therefore be properly remunerated. For the credit of the council of this enterprising city, we trust that no spirit of niggardliness will prevent the present incumbent from receiving that just compensation which is so clearly his due.

## THE "STRATFORD" HOSPITAL, BRANTFORD.

The opening of this noble charity took place on the 19th ult., and was made the occasion of a very interesting gathering. Among those present were the Lieut. Governor Robinson, of Ontario, and Mrs. Robinson, Col. Denison, Judge Sinclair, Dr. Chas. O'Reilly, Medical Superintendent of the Toronto Hospital, Dr. W. T. O'Reilly, Inspector of Prisons, Mayor Scarfe, of Brantford, and others. The ceremony of presenting the Hospital to the city was performed by the Lieut. Governor. An address was read by Mr. Stratford, the donor, welcoming the guests and referring to the substantial character of the building and its adaptability for the purpose intended. There will be accommodation for from 40 to 50 beds. The building is well appointed in every respect, and especially as to bed-space, sanitation, drainage, etc. He publicly acknowledged the receipt of many valuable suggestions from Dr. Chas. O'Reilly, of the Toronto Hospital, Dr. Digby of Brantford and others. One of the conditions of the gift is as follows:—"The management of the hospital shall be strictly non-sectarian in its character and the institution be open to all citizens of the city, subject of course to the rules that may be laid down hereafter for its conduct; that no clergyman, priest, or member of a religious sect or other society shall hold religious or other services within its walls or grounds, except a patient shall request the attendance of such, and then only for that patient's personal benefit. He said "that it was not without the most serious consideration, and after making many enquiries from those who had been and were connected with hospital working, that he appended this condition. Hospitals were purely for the relief of the sick and wounded. Cases admitted therein were mostly serious and required urgent and careful attention. If the patient is insensible he cannot require spiritual advice, but if sane, it is he himself who should say if he wants religious ministrations. Under this condition the patient has full power to send for any adviser as may wish, but otherwise no religious adviser will be allowed to interfere with him. A Medical Superintendent of a large hospital, to whom he had submitted this condition, said:—"I fully approve of it, and it would be better for the proper working of every

hospital were such a rule rigidly enforced, and it is becoming the hospital law in hospitals where it does not already obtain, and where circumstances will admit of its introduction.'"

The Mayor thanked the donor in the name of the city; and the Governor, after some appropriate remarks, declared the hospital opened. At the conclusion a reception was held and the visitors exchanged cordial greetings with the citizens. The band of the Dufferin Rifles furnished the music for the occasion. We cannot conclude our remarks without again referring to the noble generosity which prompted this act, and it is to be hoped that the example will be followed by wealthy and benevolent persons in other cities in Canada.

**THE CHOLERA.**—The Medico-Chirurgical Society of Montreal held a special meeting on the 13th ult. to discuss matters relating to the prevention of cholera, and the proposed health bill for the Province of Quebec. The meeting which was a very interesting one was largely attended. Dr. Larocque, city medical health officer, read a short paper on the subjects for discussion. Dr. Howard said that the Dominion Government should enforce the quarantine regulations; but it remained for the local government to see that proper sanitary laws were enacted and enforced. Dr. Hingston deplored the absence of any health law, and recommended the adoption of the Ontario Act with certain improvements.

**CHILDREN IN LOS ANGELES.**—Dr. Lindley in commenting on the low death rate among children in Los Angeles says:—"The reasons for this light mortality are: 1. The diurnal breeze from the ocean, which constantly purifies the atmosphere; 2. The constant ripening of fruits—oranges and lemons in the winter; apricots, nectarines, peaches, and berries in the spring; apples, pears, and grapes during the summer and autumn, and strawberries all the year round; 3. Every variety of vegetables fresh each month in the year; 4. The great number of clear days which, "renders possible an outdoor life almost every day in the year."

**CHRONIC BRIGHT'S DISEASE.**—Dr. H. Corson writes in one of our exchanges that after all the usual remedies now in use for the treatment of Bright's disease had failed, his patient having been

considered beyond recovery, he resorted to a treatment practiced many years ago. The patient was put upon a pill of calomel, digitalis, and squills, of each one grain, to be given three times a day. Morphine, chloral, or both combined, were given at night to relieve pressure and procure sleep. After keeping the system moderately under the influence of the calomel for two or three weeks, the symptoms rapidly disappeared.

**STANDARD DISINFECTANT.**—In an article in the *Medical News*, January 10th, '85, Dr. Sternberg, U. S. A., suggests a combination of permanganate of potassium with the bichloride of mercury, for common use as a disinfectant and deodorizer. The color of the solution would be a safeguard against its being accidentally drunk. No chemical reaction takes place when these substances are combined; in other words they are perfectly compatible. A solution of two drachms of each of these salts to a gallon of water would be strong enough for all practical purposes. This gives about one part of each to 500 of water.

**EXCURSION TO EUROPE.**—A number of attractive excursions during the coming Spring and Summer are announced by Messrs Thos. Cook & Son, the well known tourist agents of New York and London, which are arranged on the most popular scale of prices. Full programmes of these trips, with maps showing the routes followed, are to be found in their monthly paper, *Cook's Excursionist*, published at 261 Broadway, New York, which they announce will be sent by mail to any one interested, on application.

**NEW YORK STATE MEDICAL SOCIETY.**—This society held its seventy-ninth annual meeting in Albany on the 3rd, 4th and 5th ult., under the presidency of Dr. Sherman of Ogdensburg. The attendance was, as usual, very large and influential and the proceedings most interesting and instructive. We give a brief synopsis of some of the papers read in another column. The most important event of the meeting was the discussion of a bill to be presented to the Legislature for the establishment of a State Examining Board. A satisfactory decision was arrived at, and it is hoped the bill will become law. The social side of the meeting was well sustained.

**SANTONINE.**—It has been demonstrated that lumbrici live in a mixture of albumen, santonine, and water, but they succumb in a few minutes in an oily mixture of santonine. Experience has proven the necessity of direct contact. Santonine powder or troches is not a good way of administration, for the santonine is then mostly absorbed in the stomach. The only rational preparation is an oily mixture which is slowly absorbed in the intestines. In any other mode it has a toxic effect with many, but given with ol. ricini is not disagreeable, and very efficient.

**GUN-SHOT WOUND OF THE CHEST.**—Dr. Powers (*N. Y. Med. Journal*, Jan. 10) reports two cases of pistol-shot wounds of the chest. In each of the cases a bullet of large size entered the lung, in the second case passing entirely through it. In neither was the injury accompanied by marked hemorrhage, nor followed by acute inflammation, and in each the patient made a speedy and perfect recovery. But slight attempts were made at probing the wounds. The wounds were not hermetically sealed, but simply dressed with antiseptic dressings, which were continued until the wounds were healed.

**THE TELEPHONIC TELEGRAPH.**—A new invention of considerable importance has been perfected recently by Dr. Rosebrugh of this city, assisted by Mr. G. Black, of Hamilton, by means of which telephonic and telegraphic messages can be exchanged through long distances on the same wire simultaneously. One important feature of the invention consists in the entire suppression of the induction which is such a nuisance in the ordinary telephone. Telegraphic signals sent over the wire cause no inconvenience to the telephonic listeners.

**INFLAMMATORY FEVER.**—The following, which is a modification of a formula by Prof. Gross, is recommended in all cases of sthenic inflammation, except where morphine may be contra-indicated:

R Liq. amin. acet. ʒiv.  
Spt. eth nit. ʒj.  
Tr. aconit. rad. ℥xx.  
Morph. sulph. grs. iss.  
Aque. ad. ʒviiij.—M.

Sig.—A tablespoonful every four hours. Liquor potassæ citratis may be substituted in some cases for the liquor ammoniæ acetatis.

**ANÆSTHETIC MIXTURE.**—After considerable experience in the use of different anæsthetics, Mr. Lawson Tait has come to the conclusion that a mixture of two parts ether and one of chloroform is the safest and most satisfactory. Other surgeons prefer the A. C. E. mixture; alcohol 1 part, chloroform 2 parts, and ether 3 parts. Both the above mixtures are rapid in their action, not unpleasant to the patient, and produce less sickness than chloroform or ether when given alone.

**APPOINTMENTS.**—Dr. M. Lavell has been appointed Warden of the Provincial Penitentiary, Kingston, and Dr. O. S. Strange, surgeon to the same institution.

Dr. G. Stewart, of Port Rowan, Ont., has been appointed Assistant Surgeon, Norfolk Battalion of Rifles, *vice* G. W. Stewart, deceased.

Dr. M. I. Beeman, of Centreville, Ont., has been appointed Surgeon, Frontenac Battalion of Infantry, *vice* J. McCammon, deceased, and Dr. R. W. Garrett, of Kingston, Assistant Surgeon.

Dr. Jas. Dorland (formerly of Hamilton Ont.) has been appointed Prof. of Practice of Medicine in Milwaukee Med. College Wis.

The following gentlemen have been appointed License Commissioners for the counties named—J. Gunn, M.D., N. Middlesex, C. M. Gould, M.D., East Northumberland. R. Douglass, M.D., N. Bruce, W. H. Blackstock, M.D., East Simcoe. A. Worthington, M.D., West Huron.

**OBITUARIES.**—The death of Chas. Clay, F.R.C.S., of Manchester, is announced in our exchanges; also M. H. Newmann, Prof. in the University of Breslau.

Dr. E. S. Gaillard, of New York, editor of "Gaillard's Medical Journal," died on the 2nd ult. The Journal will be continued under the management of M. E. and E. W. Gaillard.

Dr. William Braithwaite, of Leeds, Eng., founder of "*Braithwaite's Retrospect*," died on the 1st ult., aged 78 years. He was the oldest medical practitioner in Leeds.

The death of Prof. Elsberg, of New York, the Laryngologist, is announced in our exchanges.

We regret to learn of the sudden death of Mrs. Dr. Winstanley at Los Angeles, Cal., on the 10th ult., formerly of this city.

**REMOVAL OF THE OVARIES AND FALLOPIAN TUBES.**—Dr. Trenholme of Montreal (*Can. Med. Record*) reports six cases of removal of the ovaries and Fallopian tubes with recovery in each case, and with good results so far as relief from the pelvic suffering was concerned. The operations were all performed during the year ending April, 1884.

**AMERICAN MEDICAL ASSOCIATION.**—The 30th annual meeting of the American Medical Association will be held in New Orleans commencing on Tuesday the 28th of April. This is a most favorable opportunity of visiting the Association and the World's Fair at the same time. The rates of travel to New Orleans from all points are as low as can reasonably be expected.

**NEW METHOD OF TREATING ACUTE INTESTINAL OBSTRUCTION.**—The London *Lancet*, Feb. 14th, in referring to the new method of treatment states that it was first proposed by Prof. Kussmaul. It consists in free washing out of the stomach and removal of large quantities of fecal matter, and has been attended with excellent results in several cases. The relief from distention is very great, and it also favors subsequent treatment by laparotomy when the latter is necessary.

**TREATMENT OF FROST-BITE.**—Dr. Doane in the *Therapeutic Gazette*, gives the following prescription which he says is excellent in frost-bite, and hopes it may be given a trial:

R Cosmoline  $\bar{z}$  i.  
Spts. turpentine,  $\bar{z}$  j.  
Acid carbolic gtt. x.

The cosmoline and turpentine are rubbed up together in a mortar, and the acid dropped in after. This is being prescribed by Dr. James R. Leaming, and many other able men in New York.

**TRANS-ATLANTIC CLUB.**—A club has been formed recently for the convenience and benefit of Trans-Atlantic students in Edinburgh. The object is to cultivate a feeling of fellowship and secure a means of social intercourse, so that students may not feel themselves strangers in the city or strangers to each other. The rooms which are at 37 Chambers Street will be supplied with home papers and journals.

**GRANTING DEGREES IN MEDICINE.**—The Uni-



versity of Vermont has announced its intention of granting degrees in medicine to registered British medical practitioners who pass a satisfactory examination in medicine, surgery, and midwifery. The fee to be charged is \$30.

**HONORS TO LISTER.**—The Emperor of Germany has conferred on Sir Joseph Lister the "Ordre pour le mérite" for Science and Arts. This is not only a testimonial to Lister, but also a generous recognition of the claims of medical science, which Germany has not been slow to recognize.

**MEDICAL SOCIETY DINNER.**—The first annual dinner of the Hamilton Medical and Surgical Society was held at the Royal Hotel on the 4th ult., and was a most successful and interesting reunion. The profession of Hamilton was well represented by many of its ablest men.

**CORRECTION.**—In our last issue we noticed among new books the work of "McNaughton Jones on Diseases of Women," giving W. Wood & Co. as the name of the publishers. It should have been credited to D. Appleton & Co., New York, as the publishers.

**BRITISH DIPLOMAS.**—Drs. J. L. Davison (Trinity) and W. D. Oakley (McGill) have obtained the M.R.C.S., Eng.

Dr. W. G. Hardy (McGill), and W. A. Ross (Toronto), have obtained the L.R.C.P. Lond.

Dr. Osler has been granted leave of absence by the authorities of the University of Pennsylvania, and sailed on the 10th ult. for England, where he is to deliver the Gulstonian lectures in the Royal College of Physicians.

**SIGN OF SCIATICA.**—An exchange says that if the patient be placed on his back and the suspected limb raised and flexed strongly, a pain appearing about the sciatic notch will be a certain pathognomonic sign of sciatica.

Why is it, considering the high standing of the profession, that medical literature in Canada is at such a low ebb, and that only two Canadian works, Fulton's Physiology and Canniff's Surgery are in circulation?

What are the requirements for the position of surgeon and assistant surgeon in the British army, and what are the duties, salary, rank in the service, and pension for disablement? Is a Canadian graduate required to take out the M.R.C.S., Eng., before presenting himself as a candidate?

QUEROR.

An answer to the following questions will be thankfully received.

1. Explain how the stomach is enabled to produce an acid secretion from the blood—an alkaline fluid; have we any means or medicines to assist or promote this action, and what are they?

2. When defibrinated blood is injected *per rectum*, why are not the corpuscles absorbed?

DENVER, Col.

#### TREATMENT OF IMPOTENCE.

Would some reader of the Lancet give his views as to the most appropriate treatment for impotence. The patient is a man 56 years of age, married, good family history, no evidence of syphilis, no venereal excesses, never ill in his life.

NEMO.

#### MEDICINE CHEST.

Would some of the readers of the Lancet offer some suggestions for a medicine chest for country practitioners. Many of us have to make long trips far from any drug store and it is desirable that we carry as great a variety of drugs as may be necessary, in as small a compass as possible.

Messrs Stevens and Sons have signified their intention of manufacturing a case that will meet all requirements as suggested at a reasonable price.

MEDICO.

[Would not A. A. Mellier's saddle bags meet the requirements? See advt.] ED.

### Notes and Queries.

Will some physician who has obtained L.R.C.P. and S., Edin., give a brief description of his trip, the expenses of the same and the requirements for the degrees?

### Books and Pamphlets.

**THE AMERICAN SYSTEM OF PRACTICAL MEDICINE.** Edited by William Pepper, M.D., LL.D., of the University of Pennsylvania, assisted by Louis Starr, M.D. In five imperial octavo volumes, containing about 1000 pages each, with illustra-

tions. Philadelphia: H. C. Lea's Son & Co. Prices per volume, cloth, \$5.00; leather, \$6.00; half Russia, \$7.00.

The first volume of this magnificent work is now before us, and the other volumes will follow at intervals of about four months. It has been in active preparation during the past three years, and is now sufficiently advanced to justify the publishers in calling the attention of the profession to it as a work in which American medicine will be thoroughly represented by its worthiest and most practical teachers. A reference to the list of contributors will show that the most distinguished men in all parts of the United States have united in bringing together this vast aggregate of specialized experience. It embraces the whole domain of medicine, including the departments for which the physician is accustomed to rely on special treatises, such as diseases of women and children, the genito-urinary organs, skin, nerves, hygiene and sanitary science, and medical ophthalmology and otology. It may therefore be regarded as a complete library of practical medicine. Such illustrations as serve to elucidate the subject have been introduced. It is a work of which every American physician may reasonably feel proud, and in which every practitioner will find a safe and trustworthy counsellor in the daily responsibilities of practice. We are pleased to observe the name of Dr. R. P. Howard of Montreal among the contributors, the subject being rheumatism and rheumatoid arthritis.

A MANUAL OF DERMATOLOGY by A. R. Robinson M.D., Professor of Dermatology, New York Polyclinic. New York: Bermingham & Co. Toronto: Williamson and Co.

This volume the author states is intended to be the basis of a future much larger and more original work, and we think it would have been as well, in view of the many works of this kind now in the market, if the author had deferred the publication until he was prepared with his more original work. The present volume is a mere compilation, but as such, fairly represents the status of the science, and is neither better nor worse than others of the kind. It will be useful to those who would prefer a concise yet accurate description of the various affections of the skin.

TRANSACTIONS OF THE MEDICAL SOCIETY OF PENNSYLVANIA.—Vol. XVI., 1884.

Here we have a large octavo of over 600 pages, recording the transactions of the above society for

its thirty-fifth annual session, held in Philadelphia on the 14th, 15th, and 16th of May 1884. Many of the papers contained in the volume are of a very high order of merit, and reflect much honor on the medical profession of the old Quaker State. It is not without deep mortification that the Canadian reader is forced to admit the fact of the long rear distance at which our societies stand, in comparison with those of our republican confrères. What is it that we lack? It is not brains; it is not sound initial instruction; it is not individual self-esteem; nor is it overweening modesty. Unity of sentiment and genuine love of country are most probably our greatest defects.

THE INTERNATIONAL ENCYCLOPEDIA OF SURGERY—A Systematic Treatise on the theory and practice of Surgery, by authors of various nations. Edited by John Ashhurst, Jr., M.D., in six volumes, vol. v. New York: Wm. Wood & Co.

The fifth volume of this admirable work on surgery embraces surgical affections of the head, eye, ear, nose, face, mouth, palate, tongue, jaws, teeth, neck, air passages, chest, breast, abdomen, and hernia. The present volume is quite equal to any of its predecessors, and fully sustains the encomiums already bestowed upon the previous volumes. Those who have not already done so, should immediately subscribe for this magnificent work on surgery.

THE ELEMENTS OF PATHOLOGY.—By Edward Rindfleisch M.D., translated by W. A. Mercur M.D. Blackiston and Son: Philadelphia.

It is a great boon to those who have not time to read all through large books, to fall in with one containing much good matter. Rindfleisch's "Elements of Pathology" is verily one of this sort, a real *multum in parvo*. Every page abounds with valuable instruction, which will not fail to repay the attentive reader for the time he may devote to its perusal.

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### Births, Marriages and Deaths.

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On the 9th ult. H. L. Kent, M.D., of Wallace, N.S., aged 54 years.

On the 7th ult., L. G. Turgeon, M.D., of Montreal, aged 48 years.

On the 18th ult., Dr. Henry Hanson of London, aged 61 years.

On the 20th ult. George E. Richardson, M.D., of Chatham, Ont., aged 45 years.

On the 20th Nov., 1884, W. M. Brett, M.D., of Arkona, Ont., aged 30 years.

# THE CANADA LANCET

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## Original Communications.

### UTERINE TUMORS.

A. B. ATHERTON, M.D., L.R.C.P. & S. ED., TORONTO.

(Formerly of Fredericton, N. B.)

CASE I.—Mrs. S.—æt 40, multipara, widow, last child 10 years of age. The patient was sent to me Sept. 29th, 1875, by Dr. White, of Hartland, N.B. She had been always strong and healthy till three or four years ago, when she began to have an increased flow at the menstrual periods, and at the same time noticed a hard lump somewhat to the right of the lower abdomen. A year ago she suffered severe pain in the abdomen and back during two or three catamenial epochs accompanied with much flooding. Since then the quantity of blood lost has been gradually growing less, while there has been a constant watery and mucous discharge. For about two years micturition has been frequent, though the urine was natural-looking and the bowels had to be kept very loose in order to have any passage.

*Present condition.*—Fairly well nourished. P. 100 and rather feeble. She complained of an unusual amount of pain since her arrival in Fredericton, probably due to her journey in the cars. On examination a large, smooth, semi-elastic tumor was found completely filling the pelvis, its lower end being exposed to view on the separation of the labia. Its surface was found united in places with the vagina, but the adhesions could be readily separated with the finger. A firm hard mass was felt through the abdominal walls, occupying the hypogastric region and reaching fully up to the umbilicus. As the menses had ceased about a week before and the patient was anxious to have an operation at once I decided to accede to her wishes.

*Sept. 30th. Operation.*—Chloroform was adminis-

tered; assisted by Dr. Coulthard. As it was impossible to get fairly at the neck of the tumor on account of want of room for the hand, I first sliced off perhaps one-fifth of the thickness of the tumor longitudinally. I then could feel its base apparently attached to the left anterior part of the cervix, and being about three or four inches in diameter. Then by means of traction with very large toothed forceps, and the use of a curved blunt bistoury set in a long handle, about two pounds of the mass were removed, leaving rather more of a stump than I could have wished. The patient however became considerably collapsed, though the loss of blood was not so very great, and I was obliged to desist from further efforts. About two hours were occupied in operating. The abdomen seemed to have flattened down completely during the operation, so that little or nothing could be felt there. The vagina was plugged with cotton wool, and  $\frac{3}{4}$  gr. morphine administered as a suppository.

Oct. 1.—Rested fairly well; vomited a good deal; passed water once; P. 112; some offensive discharge; cotton wool tampon removed. There has been very little hemorrhage. Vagina to be syringed with warm carbolized water every three or four hours, 3 j. ad. Oj.

Oct. 2.—Vomiting continues troublesome. Not much pain. P. 108. Discharge very fetid. Injections to be continued frequently.

Oct. 3. Doing well. P. 100; discharge as before.

Oct. 4. Ate potato yesterday, and bowels are a little loose to-day. P. 108. Quinine mixture ordered, also careful dieting.

Oct. 5.—Bowels better. P. 104. Three bits of sloughy tissue came away yesterday. Discharge still offensive.

Oct. 7.—Discharge less foul for last two days.

Oct. 11.—Discharge is lessening. P. 100. Patient sat up three hours to-day.

Oct. 18.—Discharge very slight. Patient sits up all day now, but looks rather pale and weak. Iron added to quinine.

Oct. 26.—Has been out of doors several times. Wishes to return home and may do so.

On examination I found the entrance to the cervical canal close to the right and posterior side of the upper vagina. The stump of the tumor filled up a good part of the latter and was adherent to

it in places. These adhesions were easily broken down with the finger. Directions were given to get Dr. White to separate any such that might re-form, a few days after getting home.

My patient was so much improved by the operation, that two or three years afterwards she ventured once more upon the sea of matrimony and became Mrs. D. She got along very comfortably until about a year ago, when she began to suffer from a nasty filthy discharge, accompanied by the feeling of something in the vagina. She has also had some irritability of the bladder. Her general condition however has been good. On examination I found a tumor filling the upper three-fourths of the vagina, and attached broadly and firmly to the latter at its posterior and lateral surfaces. I could not well get at the attachment to the cervix uteri on account of the size of the tumor and its extensive adhesions. The fundus of the uterus could be felt through the abdominal walls in the right hypogastric region, reaching nearly to the umbilicus.

*April 12th, 1883. Operation.*—Chloroform was administered, assisted by Dr. Coburn, of Fredericton. I first cut a slice from one side of tumor as before, in order to reach its uterine attachment, which I now found to be only about  $1\frac{1}{4}$  inches in diameter. This was first severed, then by dint of traction with forceps, cutting with scissors and knife, previously described, and tearing away with the fingers, the whole mass was slowly detached from the walls of the vagina and removed.

Great care was needed during this procedure to avoid penetration of the thinned recto-vaginal septum. The operation lasted about three hours, and I was ably assisted by Dr. Coburn in its successful accomplishment. Although the loss of blood was comparatively slight, yet the patient suffered considerably from the shock, as after the first operation. Her general condition, however, was better on this occasion previous to operating, and she rallied in a short time. The vagina was tamponed lightly with some pledgets of salicylic silk wrapped in carbolized gauze. The amount of tumor removed was about equal in size to a foetal head at full term.

April 13.—9 a.m. Doing well, had  $\frac{1}{4}$  gr. of morphine last night. Some vomiting, P. 76, T. 99°. Tampon removed. Vagina to be washed out three or four times a day with warm carbolized water.

April 14.—P. and T. as yesterday.

April 15.—Less discharge since operation than before. Some looseness of bowels, attributed to her taking some beef-tea yesterday. She states that she is always easily upset by changes of diet. P. 88, T. 99.5°. Paregoric in drachm doses pro re nata for the diarrhoea. Also to have dry farinaceous food.

April 16.—Bowels better. P. 84, T. 98.8°.

April 19.—Discharge is very slight. P. 80, T. 98.8°. May sit up a little, and can have a boiled egg and a potato every day.

April 24.—Catamenia came on to-day, being the regular period for them. P. and T. normal. Sits up several hours every day.

April 29.—Has been going about the house for two days. Menses have ceased. On examination the cervix felt large and expanded, the whole uterus also seemed heavier than normal. No trace of tumor found anywhere, unless it might be two or three small hard prominences at the upper and posterior part of the vagina, of the size of split marbles. Some purulent matter was also found in the vagina. The carbolic injections to be continued two or three times daily. Asks to go home to her family. May do so tomorrow. December, 1884, I received a note from the patient stating that she seemed perfectly well and entirely rid of the old trouble.

CASE II.—May 29, 1880. Mrs. H. æt 39, multipara. The youngest child is six years old. Generally healthy till eighteen months ago, when she began to have menorrhagia, and the intervals between her periods became shorter than usual. During the last six months a colored discharge has been present about half the time.

*Present condition.* Countenance pale, rather thin in flesh, complains a good deal of back-ache, pulse weak. On examination, a small, firm polypus was felt in the cervical canal, about the size of a large hazel-nut. The uterine cavity measured  $3\frac{1}{2}$  inches.

*Operation.* Chloroform was given because the patient was very nervous. The polypus was removed by the scissors, and a piece of cotton wool wet with carbolic acid and glycerine passed into the cervix, and one or two dry pledgets applied over it.

May 30.—Cotton wool removed. Warm carbolized injections to be used three or four times a day.

June 21.—Patient did perfectly well for a week

or two after the operation, but for a week past she has had pains in the back, accompanied with menorrhagia. On examination, a rather soft, solid mass was felt pressing down into the upper cervical canal anteriorly, which at first thought I suspected might be the somewhat inverted wall of the uterus. The sound however could be passed  $2\frac{1}{2}$  inches beyond its lower border of union with the body of the uterus, and I therefore decided that it was a tumor in the wall of the latter.

**Operation.** Chloroform was administered assisted by nurse. The presenting surface of the mass was seized with a vulsellum forceps, and with the help of blunt scissors and fingers, the tumor was gradually enucleated. It proved to be about the size of a small orange. The free surface measured about  $1\frac{1}{2}$  inches across, the remainder of the tumor of course having been embedded in the anterior uterine wall. Very little hemorrhage attended the operation. Pledgets of cotton wool were applied as before.

June 22.—Cotton wool removed, carbolized injections to be used three or four times a day. Little or no disturbance from operation, pulse and temp. being as they were previously.

June 25.—Doing well, very little color in discharge and she suffers no pain.

June 30.—Was up about the room two days ago without leave, and since then there has been some bloody flow.

July 2.—Discharge has ceased, the patient is up and dressed.

July 17.—Has continued free from discharge, and left for the country to-day.

nursing, dieting, and a careful attention to hygienic conditions, to guide the patient through the crisis back to health. In order to reach the subject in a practical way I shall narrate briefly the history and treatment of three cases, and conclude with a few remarks upon the same.

**CASE I.**—February 6, '84, I was called to see J. H., aged 30, a strong, full-blooded, vigorous man; found him suffering from pleuro-pneumonia. The day previous he was attacked with chills, violent headache, and sharp stitch-like pain in the side. Pulse 120, temp.  $105^{\circ}$ , resp. 36. The middle and lower lobes of the right lung were consolidated. Gave minim doses of tr. aconite rad every two hours combined with three grain doses of quinine; pulv. Doveri., grs. viii, to be given occasionally to relieve pain. Applied mustard over the whole of the right lung, to be followed by hot wheat-bran poultices, changed every two hours; bled to  $\bar{x}xx$ . Saw patient three hours after bleeding; resp. 32, temp.  $101\frac{1}{2}$ , pulse 112, very soft and full. Expectoration, which has been profuse and "rusty," almost stopped; cough much less severe; delirium and subsultus developed.

7th, Patient much more delirious; mouth dry and parched; pulse 133, temp. 103, resp. 32. Stopped aconite and ordered tr. digitalis and am. carb., continuing quin. sulph., grs. iii, every four hours; also to have six ounces of brandy in milk daily. For four days and nights the delirium continued; chloral hydrate and bromide of potassium, single and combined, within the limits of safety, failing to produce sleep till the fifth night after the bleeding, when he fell into a slumber so profound that he had to be awakened by his attendants. On the fourth day after the bleeding the consolidation had almost disappeared. Acute pain from pleuritic adhesions came on, which was relieved by strapping the chest with adhesive plaster. Under the digitalis the pulse fell from 133 to 112 on the second day after the bleeding, and on the third had fallen to 100. The patient was much exhausted on recovering from the delirium. The pulse remained at 100; tongue brown, dry and parched. He also suffered from moderate diarrhoea, which I did not think proper to check. As the delirium went on I increased the daily amount of brandy to eight ounces; also gave him all the milk he could be made to take. The recovery was very tedious.

**CASE II.**—On the same day that I made my

## THE MANAGEMENT OF PNEUMONIA.

BY M. C. ATKINSON, M.D., BRISTOL, N. B.

Perhaps there is no disease about the treatment of which physicians differ more than pneumonia. There have been, and there still are, two general modes of treating this disease. The first, the antiphlogistic treatment: the second, the expectant plan. By the first it is hoped to cut short the course of the disease or stay its progress. To this end tartar emetic, aconite, and veratrum viride are administered and venesection performed. By the second plan we hope by careful watching, by restraining the violence of the fever—by good

first visit to Case I, I was called to see a niece of his, a young woman aged 19, of robust habit. I found her suffering from the same disease, having also been attacked the day previous. Her pneumonia was but slightly complicated with pleurisy. There was extensive consolidation of the right lung, extending from the lower portion of the upper throughout the middle and lower lobes of the right lung. Sputa "rusty" and tenacious, tongue dry and brown, hectic flush on each cheek; resp. 44, pulse 130, temp. 104 $\frac{2}{3}$ . I also found congestion of the lower lobe of left lung posteriorly. The same treatment with reference to mustard and poulticing was pursued here as in the preceding case. I also gave the patient two grain doses of quinine every two hours, and am. carb., and tr. digitalis, in ten grain and ten minim doses respectively, every four hours.

*February 7.* Again saw patient; pulse 135, temp. 103, resp. 48. Crepitation over the upper lobe of the right lung becoming coarser; fine crepitation over a small portion of the left base posteriorly. Ordered four ounces of brandy in milk daily; digitalis and am. carb. to be continued.

8th. Pulse 144, temp. 102 $\frac{1}{2}$ , resp. 52. Taking a good deal of nourishment. Ordered all the brandy that she could take. Continued the am. carb. and digitalis; ordered frequent sinapisms to the whole chest. The pneumonia of the left base, luckily for the patient, did not extend.

10th. Patient remained in much the same condition, and I regretted that I had not used the lancet. I did not see her again till the 12th, when I found that a great change had taken place. Incredible, as it may appear, the pulse was 63 and occasionally intermitted, temp. 101, resp. 24; tongue beginning to clean. I immediately stopped the digitalis, am. carb. and brandy; kept up the quinine, and ordered free nourishing liquid diet. The patient made a very rapid recovery, and was able to attend her ordinary work a fortnight before her uncle got out of bed.

CASE III.—*F.b.* 27. Was called to see a man, aged 27 years. He was a large, full-blooded, powerful man, weighing over 200 pounds, somewhat addicted to drinking. He had been attacked that day with severe pain in the right side, embarrassed and painful breathing; pulse 112, temp. 102; some diminished resonance on affected side and tubular breathing, but no crepitation; an

occasional cough, but no expectoration. Gave a saline purge and bled fully twenty ounces; gave tr. aconite rad., m iv., every four hours; ordered mustard and poultices to side alternately.

*March 1st.* Again saw patient. Crepitation now distinct over the anterior portions of the right lung, middle and lower lobes; abundant rusty sputa; pain in side somewhat easier; pulse 100, temp 102 $\frac{1}{2}$ .

3rd. Patient in much the same condition. Pulse, however, running up to 115, temp. 102, respiration laboured.

4th. Pulse and temperature the same, respiration very laboured. Marked nervous prostration, delirium and stupor; cannot answer intelligibly. Discontinued aconite; ordered ara. carb., vin ipecac and quinine, also six ounces of brandy daily.

5th. Pulse 95, temp. 100, respiration less laboured; patient more rational.

9th. Very great improvement in every way; still very weak.

13th. Convalescing. The patient recovered very slowly, the lung remaining consolidated for a long time.

So much for the history of these three cases. Now, I think the point upon which we differ most is the question of venesection. This question has been discussed, and is still being discussed, by some of the best men in the profession, and they differ very much in opinion. Now, what mainly are our objects in bleeding in pneumonia? To prevent death from suffocation; to unload the right side of the heart. Is it a common thing for death to occur in pneumonia from suffocation? For my own part, I have never seen death from this cause, and have read of very few, and I believe that the experience of the profession generally coincides very nearly with mine. But some claim that bleeding favours absorption? This is easily affirmed, but difficult to prove. In case first absorption occurred very rapidly. In my third very slowly. Both were good subjects for bleeding; in both I employed venesection. In case second, a good subject for bleeding, I withheld the lancet; but absorption occurred here also with extreme rapidity. Now, I have treated a large number of cases of pneumonia in the last two years, in two only have I employed venesection, and, of all my cases, these were the most prolonged and

tedious, and in these the nervous phenomena occurred in a manner most marked, when contrasted with those cases which I had treated upon general principles. Now, it is also said of bleeding that it cuts short the disease if employed in the congestive stage. To this I can say, it may sometimes; it does not always. In case third I employed it in the congestive stage, with the result narrated. The pneumonia went on. Still in the case of a strong, full-blooded young man, seen early, and having marked dyspnoea, with the blueness of the face and a turgid condition of the venous system; with a small pulse and laboured action of the heart, showing that the right ventricle was distended and, in the left, scarcely any blood upon which to contract, I cannot but think that the lancet should be used. But how much blood will you take? Some say eight, some say ten, some twenty, some thirty, thirty-five or forty ounces of blood at once. I consider this a point of the greatest importance. I believe that in pneumonia an exception must be made to the general rules laid down with reference to blood-letting.

The average amount of blood in an ordinary man is eighteen pounds; in a full-blooded man of good size we might approximate the amount at twenty pounds. In an extensive pneumonia of one lung you will have four or five pounds of blood, or of material from the blood, thrown out as exudation; in double pneumonia nearly double that amount, viz., eight or ten pounds, leaving in a full-blooded man fifteen or sixteen in single, and ten or twelve pounds in double pneumonia. Now, this fifteen or sixteen pounds of blood in a single pneumonia is not only very much less than what is necessary to carry on the work of the economy, but it is also much deteriorated by the products of inflammation on the one hand, and by defective aeration on the other. Now, what must be the result if you take one and a-half, two, or two and a-half pounds of blood from the veins of a man when it has already been so fearfully drawn upon? The brain, we are told, requires one-seventh of the blood, viz., something over two and a-half pounds. Taking the amount in exudation and making a little calculation, you will find that you have a reduced blood supply to the brain of nearly one-half. Now, you will find, if you do this, the nervous symptoms, which may have been

mild before the bleeding, will become pronounced in a short time after the bleeding. Take a man in full health and bleed him to the extent of seven pounds—few of us would care to do it—and yet that man is able to reproduce the lost blood in a short time, because his powers of assimilation and absorption are unimpaired; but the man who suffers from pneumonia is in no such condition, the whole system is profoundly disturbed, and the blood-producing powers almost at zero; and yet there are some who would not hesitate to take two or two and a half pounds of blood. Now, if this is a strong case in single pneumonia, what must it be in double pneumonia?

Here you have eight or ten pounds of exudation taken from the blood, ten or twelve pounds left in the body—say you have twelve pounds left in the body. You take away two more; you have ten left—just half the blood, and loaded with the products of inflammation and very improperly aerated. It does appear to me that a physician should be sure of his case before he would adopt such heroic measures. Bad as is the mortality of double pneumonia under the cautious, conservative, and I believe, judicious treatment of late years, I am persuaded that it would be woefully increased by such a measure. Even in the case which I have drawn as being one in which it would be appropriate to use the lancet, the quantity taken should not be large: not above eight or ten ounces, or, at the outside, twelve ounces. In the cases in which I adopted it I believe I withdrew too much. I am led to this conclusion by the very marked nervous prostration and tedious convalescence which followed the measure. Another point: When should you bleed in pneumonia? In the congestive stage. It is then that the right side of the heart is loaded; it is then, if at all, that you may hope to cut short the disease; it is then that you may hope to lessen its severity. If you wait till exudation is completed and then bleed, you only further debilitate a patient already sufficiently debilitated, and narrow his chances of recovery.

#### AN ADDRESS READ BEFORE TRINITY COLLEGE MEDICAL SOCIETY.

BY G. A. BINGHAM, M.D., TORONTO.

Demonstrator of Anatomy.

MR. PRESIDENT,—When informed that your committee had honored me by appointing me to



read a paper before you to-night I was at first puzzled, and then a feeling of actual helplessness began to overcome me as I took in the full force of the situation. In order to read a paper one must have a subject. The subject upon an occasion such as this should be fresh and entertaining, for if I understand properly the object of these reunions—these open meetings of your society, we are not here to listen to the dull technicalities of science or philosophy, nor to have exhibited to us the awful niceties of the surgeon's blade, nor to endure panegyrics upon the virtues of Gossypium or Jaborandi. All these delicacies are, no doubt, done full justice to at your regular meetings. But upon occasions such as the present, whether as friends, medical students, or practitioners, we are for a time to throw aside the cares of everyday life, and banish from our minds all thought of the morrow's burdens, and while this hall resounds with the inspiring strains of old "Litoria," the physician is to fancy himself once more, as in "Auld Lang Syne," sacrilegiously carving his name in undying letters upon the furniture of his alma mater. And those friends who have honored us by their presence to-night are to wish that they, too, had been medical students. No wonder, then, that I was puzzled to select a subject suitable for such an occasion. In my despair I appealed to your worthy President, and he blandly suggested that in my paper I should attempt a solution of the conundrum of the nineteenth century. Fellow students you will perceive at once the inappropriateness of such a subject, for, while we all concur in the determination never to give up that conundrum, we are all equally agreed that its solution, like many other grand mysterious dispensations of Providence, is completely beyond our powers. Thus thrown upon my resources I thought of writing an essay on "How to prevent the cholera invasion," but, as my remarks would probably never have been even heard of by the International Convention, fortunately for you I abandoned that idea. Then the idea of writing up the trials of medical students suggested itself to me. The medical student! The professor's pride and the policeman's pet—that anomalous being so little understood by those among whom he lives,—accused of all the misdeeds in the calendar of crime,—persecuted, frowned upon and laughed at by those who may some day invoke the aid of his

skill to rescue them from an untimely grave (and it is needless for me to state that assistance will be magnanimously, I may say even cheerfully, extended at the maximum rate of two dollars per bottle). And yet, Mr. President, anyone who is thoroughly acquainted with the actual condition of affairs must acknowledge that we have no class of students who labor more assiduously to prepare themselves for future usefulness;—none who so honestly strive to master the details of that mighty principle which underlies the alleviation of human misery; and none, when occasion calls, who so willingly brave contagious disease and death for the benefit of their fellow-beings. Speaking of medical students one is naturally brought to the consideration of a subject which, did time and your kind patience permit, I should have liked more particularly to dwell upon—I mean the preparation of the medical student for his life work, and what share literary education should have therein." I have no doubt many will exclaim, "The science of medicine is of itself sufficiently extensive to occupy our whole attention." I thoroughly agree with you, my friend. My recollections are too painfully vivid for me to forget the midnight toil and the early hours of the medical student. I cannot yet obliterate from my memory the total absorption of one's mental faculties in the mighty volume of "*Gray's Anatomy*," until one's very hair threatened to partake of the nature of the subject and turn—*Grey*.

Nor do I forget the painful delvings for grains of diagnostic truth in the stony bosom of "*Flint*,"—and the steadily increasing burden of work as the session approached its close, until one had not even time for those devotions at the shrines of Bacchus and of Venus, which some well-meaning but misinformed people consider so essential to every properly constituted medical student.

Notwithstanding these facts I cannot but believe that, if the preliminary education of a medical student possessed more of a literary character, it would not only enhance his future usefulness, but would increase his facilities for attaining to prominence in the pursuit of his medical course.

We have, to-day, medical men occupying some very high positions in this country of ours. The legislative halls of Canada contain many representatives of our profession. We are all proud to know that a former graduate of our beloved Alma Mater now occupies a position in the cabinet of

Manitoba; and another member of our profession is our representative in England as High Commissioner (some call him our *very* High Commissioner, whatever that may mean). In view of the fact, then, that our fellow-countrymen have been pleased from time to time to select from our midst men to represent them in the councils of the nation, it behoves us all so to prepare ourselves that, should it ever be our lot to be so chosen, we should do honor, not only to our country, but to our profession.

But in what way would literary training be of *direct* advantage to a student of medicine? While the study of classics, ancient or modern, or the acquiring of the romance languages, or the research after great mathematical truths, may not have any direct bearing upon the study of medicine, yet who will deny their influence in strengthening the mind and expanding the intellect? Who will deny that he whose intellect has been cultured and strengthened by familiar intercourse with the philosophers, the moralists, the statesmen, the historians, or the poets, of ancient or modern days, is better fitted to pursue the researches into the mysteries of growth and decline, of health and disease, of life and death?

Undoubtedly a liberal literary education will inculcate habits of study, discrimination and discernment, all invaluable accessories to the student of medicine; and he will indeed be a public benefactor, a servant who has nobly served his country, who will, by some means at present unknown, reconcile the laborious life of a medical student with the attainment of literary knowledge; and he will certainly deserve to have engraved upon his tombstone the epitaph, suggested, I believe, by Mark Twain for his poor old servant, who, in a state of inebriation, fell upon the red-hot stove and, before being rescued, was burned to a crisp: "Well done, good and faithful servant."

In conclusion, gentlemen, I would say: Make the science of medicine your first love, and lovingly array her in the mantle of literary excellence, bedeck her with the gems of culture, adorn her with the priceless diamonds wrested from the bosom of literature; and then, and not until then, will you have done justice to your heart's first love, your chosen science; and then, and not until then, will that science stand forth flashing with the peer-

less rubies of truth, and, exalted upon a pedestal far above the petty tyranny of prejudice, will receive as homage, the appreciation and admiration of all men.

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### Correspondence.

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#### TO THE MEDICAL ELECTORS OF KING'S AND QUEEN'S DIVISION.

GENTLEMEN,—Ten years have now elapsed since I addressed you as a candidate for this division,—since which time I have closely attended to your interests as your representative in the Medical Council. Whether I have succeeded in fulfilling these duties—my record is before you; you are the judges.

I have again been solicited by a highly respectable number of my professional brethren to offer myself as a candidate for your suffrage in 1885. It is very gratifying to me to have such a respectable number of my friends come forward, many of whom unsolicited have appended their signatures to my nomination paper. Some time ago I had every intention of retiring from the responsibilities of office, but was so strongly urged once more to enter the arena I could not do otherwise than allow my name to be used for that purpose. Many of you have certainly given me more credit than I deserved for alleged zeal in your behalf. Allow me to state that I have always been devotedly attached to the medical profession—not so much for the emoluments as for the scope which it offers for mental gratification in the cause of suffering humanity, although we sometimes receive the doubtful honor of unmerited abuse from many of those whom we often risk our own lives to serve without any reward whatever. However, we have hours of happiness in the thought of doing more real good to mankind than all the other professions put together. It is altogether unnecessary for me to say much on the duties devolving on the members of the Council. I might say, however, that it is in contemplation to have the Medical Act amended. Some of those amendments I approve of, others seem to me of rather doubtful propriety—such as the increase in our annual assessment. I have not yet seen a medical man in this division who approves of such a step. The law also ought to be amended whereby actions for

malpractice shall be brought within a limited time and security given by the plaintiff for costs incurred in the bringing of such suit. In the majority of cases tried the plaintiff is some miserable creature, with scarcely the coat on his back or even the will to earn it. To say nothing of the trouble and anxiety, the loss to the defendant is very great whether he is successful or not; not unfrequently ruin is entailed and probably his prospects blasted for life. There are other improvements that might be stated, the nature of which I shall not enter upon; but if you should feel at liberty to tender me your vote it shall be my pleasing duty to do everything in my power to promote the honor and dignity of the profession generally.

Thanking you for the confidence you have so long reposed in me, I have the honor to be, gentlemen,

Yours sincerely,

W. ALLISON.

BOWMANVILLE, 9th March, 1885.

## Reports of Societies.

### ONTARIO BOARD OF HEALTH.

The regular quarterly meeting of the Ontario Board of Health was held in Toronto on the 12th ult.; present: Drs. Covert (Chairman), Cassidy, Rae, Yeomans, Oldright, and Bryce, the Secretary. The Secretary read a communication from Mr. Crown, of Sault St. Marie, relating to the proximity of the burying ground to the dwelling houses. A communication from Dr. Harris, Medical Health Officer of Brantford, asked if the municipal authorities in Ontario had power to regulate the cutting of ice. Dr. Bryce stated there was no provision in the Municipal Act regulating the cutting of ice, but he understood that Mr. Badgerow was going to submit a resolution to the Local Legislature making provision for the same. The question of preventing the existence of cemeteries within a certain distance of dwelling houses was also to be considered by the Legislature. The Secretary made his quarterly statement of the work done in connection with the smallpox outbreak in Hungerford township. When the Provincial Health Board authorities had entered the affected district the spread of the disease was most effectually stopped. The desirability of establishing a vaccine farm in connection with the Experimental Farm, at Guelph,

was discussed and a committee appointed to confer with the government in relation to the matter. The Board adopted the following memorial to the Dominion Government on quarantine regulations: 'That in view of the probable introduction of cholera into this continent, and of the fact that smallpox has been introduced into the province by immigrants several times during the past year, the Board would respectfully submit the following additions to the regulations already in force for preventing the introduction of contagious diseases:

1. Clean bills of health to be issued by the District Medical officers to emigrants purposing to embark at a foreign seaport.

2. Appeal to the Government at home for arrangements whereby the quarantine officers at the various seaports of our Dominion might by cablegram be advised of the departure of vessels from English ports having on board emigrants from infected countries. Provisions also at ports of departure for suitable buildings in which intending emigrants on whom infectious diseases have developed may be cared for until convalescent.

3. Precautions to be observed on board ships carrying emigrants during a time of prevalence of cholera or smallpox. In proportion to number of emigrants carried, space to be set apart in a suitable portion of the ship for an isolation hospital with greater provision for free ventilation.

4. During the prevalence of cholera the premonitory diarrhoea should be carefully attended to; excreta received in vessels containing one pint of a solution of mercuric chloride and permanganate of potash, of the strength of two drachms of each to a gallon of water; body and bed linen, if soiled, to be destroyed, or immediately placed in soak and boiled in same solution.

5. Quarantine stations to be supplied with boarding stations, consisting of suitable wharves and boats for (1) boarding vessels and for transportation of the sick; (2) places of sequestration for those that are well, but have been exposed to the disease during the passage and have not yet passed the period of incubation.

6. Hospitals for the sick with various infectious diseases, to be placed at distances apart, to prevent the germs of one disease being transmitted to another.

7. Vessels on arrival should have the following points established:—(1) Sanitary condition of port

of departure ; (2) Sanitary condition at time of leaving ; (3) History during passage ; (4) Sanitary condition on arrival, with reference to cleanliness of quarters of steerage passengers and crew.

#### BRANT COUNTY MEDICAL ASSOCIATION.

The usual quarterly meeting of the Brant County Medical Association was held in Brantford, on the 3rd ult. There were present Dr. Marquis, Mt. Pleasant, President ; Drs. Philip, Henwood, Griffin, Digby, Winskell, Secord, Branford ; Dr. Kitchen, St. George ; Dr. Fairchild, Mt. Vernon ; and Dr. Davidson, Langford.

It was moved by Dr. Digby, seconded by Dr. Philip, That a resolution which was adopted at a former meeting of this Association in reference to contract practice be rescinded.—*Carried.*

Dr. Philip exhibited a tumor (steatoma) of large size and many years growth which he had recently removed from the shoulder joint. The wound had healed by first intention.

Drs. Digby and Kitchen were appointed to read papers at the next meeting of the Association.

After some routine business had been disposed of the Association adjourned until the first Tuesday in June.

### Selected Articles.

#### OVARIAN TUMOR IN A YOUNG GIRL.

Clinic by Prof. Thomas, New York.

Our first patient to-day is Margaret H—, born in Nova Scotia, aged eighteen and single. The history which she gives of herself is a very striking one in many respects. She says she has been sick for two years, and that up to two years ago she was perfectly healthy. At that time she had a very hard fall, striking flat on the abdomen, and the next day there came on a very severe uterine hemorrhage. This flowing continued for several months—three at the least—and she says she then called in a physician, who gave her some medicine which gradually stopped it. Since then, however, there has never been any return of the menses ; but, as time went on, she noticed that her abdomen was gradually growing larger. She is now as large as a woman ordinarily is at the eighth month of utero-gestation, and she says there has been no menstrual discharge for at least eleven months.

The abdomen of this young girl presents, then, a large hard mass, and she comes here to-day to find

out what the trouble is. Suppose that, instead of coming to the college, she had gone to the private office of any one of you. You can see at once that very delicate questions would have arisen for you to decide, and that a great deal would have depended on the diagnosis which you made ; for the case is one of importance in many ways. In the first place, she might have slipped on a sidewalk of a city like this, and, attributing all her trouble to the fall, might have called upon you for an opinion which would justify her in bringing suit for damages against the municipal authorities for the condition of the streets. Thus, next week I shall have to make an examination in the case of a woman who slipped and fell three years ago, and who ever since has suffered so greatly from dyspareunia, that marital life is a serious burden to her. In consequence of this she is bringing suit for \$12,000 against the city, and I shall have to be extremely careful in expressing an opinion as to whether or not the trouble of which she complains is really attributable to the injury incurred in the fall.

Another important point to decide here is, what sort of an abdominal tumor is this, and what connection has the amenorrhœa with it ? Perhaps the amenorrhœa may be natural, and the tumor a living one. As to the statement of the patient that it has continued for eleven months, that should have no weight whatever in affecting our opinion of the case. Many instances have, unfortunately, occurred in which the abdomen has been opened and the trocar plunged into a tumor supposed to be ovarian, which proved, to the operator's chagrin, to be nothing more or less than a gravid uterus. If utero-gestation should really exist, and you should express the opinion that this was not the case, or if just the opposite of this should be true, you can readily see in what an unpleasant position you might place yourself. Let me show you, then, how I would advise you to conduct your investigation in a case like this, in such a way as to avoid error and arrive at the truth. The problem you have to solve is, what is the character of this tumor, and what its connection with the uterine hemorrhage and the subsequent amenorrhœa ?

What, now, might it be ? It might possibly be any one of thirty or forty different things ; but the most of these conditions are so exceedingly rare as to render it unnecessary to take them into account at all. What, then, are the things it is really likely to be ? First of all, in every such case you should always, without any exception whatever, think of utero-gestation. Even if it were one of the vestal virgins themselves, let this be the first supposition on which you proceed with your examination.

At the period of pregnancy, when the abdomen is as large as in the present instance, the cervix ought to be quite soft and a little patulous, and the markedly protuberant anterior wall of the uterus

bulging in front of it ; while through the os something hard (whether the head or the back of the child) should be felt moving up and down. Instead of this state of affairs, I found on examination here the cervix and uterus of a virgin, and venturing, on account of this, to pass the probe, it entered the cavity, which I ascertained to be empty for two and a-half inches, and in a direction which showed the uterus to be turned backwards. But, notwithstanding all this, the patient might still be pregnant ; for this might possibly be one of those rare cases where there is a double uterus. I began therefore, my examination on the outside of the abdomen. If in a case of pregnancy you keep your hands steadily upon the uterine tumor for some time, you cannot fail to detect a hard mass and the movements of the child. Then, with careful auscultation you ought to be able to distinguish the foetal heart-sounds, the so-called placental *bruit*. The latter is in reality a uterine *bruit*, however, as the sound is caused by the rushing of the blood through the uterine sinuses. Nothing of the kind was found in this case ; nor were there any mammary indications, or any other sign of utero-gestation whatever. This hypothesis is, therefore, to be discarded.

Secondly, the abdominal enlargement might be caused by a uterine fibroid ; but in that case the tumor would be very hard and unyielding. Here, on the contrary, I can get a distinct wave on palpation. Has the patient, then, ascites, which might perhaps too be due to disease of the liver, or of the peritoneum ? If this were the case, there would be perfect resonance on percussion at the upper part of the tumor, from the fact that the intestines would float on the top of the water. There is, however, not a trace of resonance at the top, the percussion-note being perfectly flat at that point, while there is resonance at the sides, much more marked on one than on the other. She has not, therefore, ascites.

We arrive at the conclusion, then, that she is probably suffering from some form of cyst. This might possibly be of the liver, the kidney, or some other organ ; but there is one kind of cyst that is so vastly more common than any other that we will be hardly likely to err if we conclude it to be of this character, and that is the ovarian. There are special reasons also for supposing it to be an ovarian tumor. The mass extends fully down to the pelvis, and it has pushed the uterus backward and downward, as we have previously ascertained. To show you how valuable I regard the former of these signs, I will mention that in a case in which I operated about six months ago, as soon as I found that there were intestines between the tumor and the iliac fossa, I confidently asserted that whatever else the growth might be, it was certainly not an ovarian cyst. The result proved it to be an enormous cyst of the kidney, its size being one and a-half times as large as my head.

So much for the diagnosis of the tumor : now for the question of its etiology. Let me caution you in the first place to beware how you give your support to the hypothesis (on which a suit for damages may be based) that because a certain difficulty from which a patient is suffering came after a fall or other injury, that it is the result of that injury. Some time ago a lady consulted me who said that she had a severe fall upon the back, and that profuse uterine hemorrhage had immediately followed. From her account, I supposed that it was probably a typical case of acute retroversion of the uterus ; but when I made a vaginal examination, what was my surprise to find that instead of this there was advanced carcinoma of that organ. Yet the patient until that time had never had any hemorrhage or other symptom to indicate the presence of malignant disease. You must be on your guard, therefore, in regard to *post hoc, propter hoc*. I doubt not that the fall was the exciting cause of the hemorrhage here, but do not believe that either the hemorrhage or the amenorrhœa would have resulted if the ovaries had been in a healthy condition at the time of the accident. I am speaking only from experience ; but in the light of that I do not hesitate to say that this girl's trouble is not due to any such cause. On the contrary, I believe that at the time she fell she had cystic degeneration of both ovaries. The fall, however, probably did cause the rupture of one or more of the ovarian cysts, and thus gave rise to the hemorrhage ; while as the hemorrhage continued, the ovary went on increasing in size.

Finally, as to the prognosis. Unless ovariectomy is performed, it is a completely hopeless one. I need not say how fully established is the point that drugs are utterly useless in this affection. You will doubtless hear of many cases of ovarian tumors which have been cured without resort to the knife ; but the explanation of this is that they have not been true ovarian cysts. It not unfrequently happens that a patient comes to an ovariotomist with a tumor of considerable size, but because he thinks it is not at the time sufficiently large to demand removal, he tells her to return to him in six months ; yet when she comes back to him at the end of that time the growth may have entirely disappeared. This is because it was a par-ovarian cyst, a simple cyst of the broad ligament, which contained nothing but pure serum ; and it is the cases of this character in which the recovery takes place spontaneously, though the cure is generally attributed to whatever medicine the patient happens to be dosing herself with at the time.

This being, without doubt, however, a true cyst of the ovary, ovariotomy becomes imperatively necessary. When, then, shall the operation be performed ? At once, I should say. The late Professor Peaslee, one of our highest authorities on the subject, was in favor of postponing the opera-

tion to the last possible moment, on the ground that the patient ought to be permitted to enjoy life as long as she could. But the fact is, that the patient cannot enjoy life with such a tumor. Its presence makes her utterly miserable, and after it has attained a certain size the sooner its removal is accomplished the better; not only because of the inconvenience and suffering which she will be spared, but because her chances of recovery will be much better than if it is postponed too long. The tumor in the present case now, no doubt, weighs twenty-five or thirty pounds, and it is high time that it should be gotten rid of.

I feel almost certain that double ovariectomy will have to be performed here; and for the reason that the patient has not menstruated for eleven months. The fall, certainly, had nothing whatever to do with this, for women are continually meeting with all sorts of accidents and injuries, but they go on menstruating just the same if the ovaries are healthy. It is the cystic degeneration of these organs, and not the fall, which has put a stop to this young woman's menstruating.

#### CYSTS OF THE UTERO-VAGINAL GLANDS.

Mrs. Ann R—, thirty years old, has been married three years, and has had one child. This is a very acute case compared with most of those that we meet here, as she says she has been sick only eight days. Eight days ago she began to suffer intense pain, accompanied with a burning sensation, whenever she attempted to pass urine, and yesterday she noticed, for the first time, a lump gathering within the vulva. This is the history.

One of the great advantages of a clinic like this is, I think, that many of the cases which you see here are likely to present themselves to your minds when in the future you meet with similar ones in your own practice; and it may be that many years from now the memory of some special case here at the clinic may enable you to successfully treat one of the same character which you then meet with for the first time yourself, and which might have otherwise proved a puzzling one to you. Thus the present case may fix itself in the memory of some of you, just as one that I will now mention did in my own. Twenty years ago a lady from the South consulted me for aggravated dysmenorrhœa; the pain coming on during the first day of the flow and being excruciating. It was before the days of the hypodermic syringe, and her suffering was so agonizing that nothing seemed to give her much relief. After remaining in New York for a number of months without receiving any permanent benefit she returned to her home in the South, where some time afterward her physician removed a small fibrous polypus, hanging by a pedicle from the uterine canal; and after that she had no further trouble. The explanation of the case was, that this little fibroid, being comparatively free in the cavity, had acted like a ball-valve in preventing the

escape of the menstrual blood, and thus set up the uterine contractions which caused the patient such extreme pain. Gradually, the fibroid worked itself downward along the uterine canal, until it was finally extruded from the cervix, when its removal became a very trifling matter.

Since then I have never met with a case in which the symptoms were quite the same as in this case until this very day, when a lady came to my office who suffers in precisely the same manner. Whether the trouble is due to the same cause I do not know; but, with the experience of the other case in mind, I shall at all events take the precaution of dilating the cervical canal with sea-tangle, and examining to see whether there is not such a fibrous polypus present; and it probably would not have occurred to me to do this if I had not come across the other case twenty years ago.

In the case now before you which, perhaps, may recur to some of you many years from now, there is a cyst of considerable size under the right *labium majus*, which is excessively painful to the touch; and under the left arm there is a similar, though smaller, cyst.

So much irritation have these cysts caused that there is now quite a severe vulvitis in consequence. If you did not make a correct diagnosis, this case might give you a good deal of perplexity; but, if you recognize its true character, you would find it one of the most curable cases to be met with in practice. These cysts are due to a degeneration of the vulvo-vaginal glands, whose excretory ducts have been closed by inflammatory action. The vulvo-vaginal glands were first described by Bartholinus, after whom they are often called; but, strangely enough, his description was lost sight of for a long time, and they were rediscovered, as it were, by M. Huguier, of Paris, in 1841. When they become inflamed vulvitis, urethritis, and more or less vaginitis, are the results, as in this case, and coitus becomes utterly intolerable. In this condition all sorts of lotions and soothing applications are oftentimes ordered; but such treatment is absurd, for the reason that the ducts of the glands, as has been mentioned, are closed by the inflammatory action. If we could probe them with the same skill that the oculist does the lachrymal duct, good results might perhaps be secured by the operation; but I have never heard of such a thing being done. The treatment that I unhesitatingly recommend in such cases is to snip off a section of the cyst (having first anesthetized the patient), and then stuff it with carbolyzed cotton. This cures permanently, because the gland soon disappears entirely after the operation. The French writers advise dissecting out the gland; but the great objection to this procedure is that a branch of the pudic artery is very likely to be severed in it, and as the artery lies very deep under the ramus of the pubes it is difficult to control the hemorrhage that results.—*Medical and Surgical Reporter.*

## GASTRALGIA.

Clinical lecture by Dr. William Pepper, published in the *Medical Times*:

This man a farmer, aged 39 years, has been sick for two years. His principal complaint is of pain in the left side. He has lived in a healthy locality, and has never had chills and fever. The pain begins in the left side and runs back to the left shoulder-blade. If he eats too much he suffers, but the kind of food taken does not appear to influence the pain. An ordinary meal does not make the pain worse, and eating sometimes takes away the bad feelings. Active exercise or riding over a rough road is apt to bring on the pain. The appetite is fair. The bowels are sometimes constipated, but as a rule he has diarrhœa about twice a week, there being two or three loose stools, but these contain no blood. He weighs one hundred and fifty pounds. His best weight was one hundred and sixty-two pounds, but during the summer he goes as low as one hundred and forty pounds.

Let me here refer to this matter of variation in weight. Many persons will be met with who have a wide range of what may be called normal weight. I never like to see this symptom, for it seems to me that those persons who lose flesh so rapidly cannot be made of very good stuff. A person whose flesh is solid and who is living a correct life should maintain pretty nearly the same weight summer and winter, varying perhaps from three to five pounds. Persons will however, be found whose weight varies twelve or fifteen pounds at different periods of the year. With such persons I have observed that sickness goes hard; on the other hand, loss of weight in them is not to be regarded as of such serious moment as it would be in a person who was thoroughly in training and whose flesh was solid and well organized.

In reference to the pain complained of, when this pain is in the right side, we naturally suspect some trouble with the liver—a gall stone in one of the smaller ducts or in the gall-bladder; some congestion in the liver, causing dragging on the suspensory ligament, or irritation of the capsule of the organ. When the pain occurs on the left side, we think of the spleen, the pleura, and the heart, and when, as in this man, the pain associates with some shortness of breathing and overaction of the heart, we are apt to think more particularly of the heart. Examination of the heart shows it to be perfectly normal. There is no enlargement of the organ, no displacement of the apex-beat, and the valvular sounds are free from murmur. Neither is there any evidence of chronic pleurisy. There is good respiratory murmur and resonance over the left side. Examination of the spleen shows that the organ is not enlarged and that the man has not lived in a malarious district.

Before satisfying ourselves that this is merely a

neuralgic trouble (possibly a form of gastralgia), some obscure conditions must be thought of. One of the most insidious of these, and one against which we should be continually on our guard, is caries of the spine. Caries of the anterior surface of the vertebræ constantly reveals itself by pain and distress in the neighborhood of the spinal column. Many cases of sciatica or intercostal neuralgia will be found to be due to caries of the anterior surface of the vertebræ, and the diagnosis should not be made until a sudden increase of the symptoms, with some numbness and failure of power in the lower extremities or the appearance of an angular projection, calls attention to the real cause of the trouble. You will do well to be on your guard against the occurrence of this obscure lesion. Aneurism of the descending aorta is another condition to be excluded.

There is no tenderness along the spine, neither is there any projection of the vertebræ, and jumping does not cause pain. No pulsation, thrill or abnormal dulness can be detected. Caries of the spine and aneurism may therefore be excluded.

You observe that the pain is described as occurring in the right side and over the stomach; it is not markedly affected by eating, although radishes and some other vegetables make it worse, and it is worse when the stomach is empty than after an ordinary meal. It is associated with evidence of derangement of intestinal digestion, as shown by flatulence and irregular action of the bowels, sometimes constipation and sometimes transient attacks of diarrhœa. Having excluded the graver causes for this pain, we must conclude that it is neuralgic and occupies the stomach, and therefore a form of gastralgia.

As to the cause of this; the family history is good, and he has good health until this affection developed. He does not use liquor or tobacco; he has not been overworked, but has gotten into the habit of eating his meals hurriedly. The gastralgia has probably been brought on by this rapid eating.

In the treatment of gastralgia the regulation of the diet is the chief element. The stomach is rarely able to receive and handle enough of food in three meals to support the system; consequently it is important that such patients should take more than three meals in the twenty-four hours.

Again the stomach is so hyperæsthetic and the mucous membrane so irritable that unless some digestible substance is in the stomach the acid juices are apt to excite pain, and hence the pain is more marked when the stomach is empty, and the ingestion of food affords relief; so that for this purpose, also, it is desirable to give food oftener than three times a day. Meals of smaller amount, and of extremely simple character, and at shorter intervals, is the rule for the nourishment of gastralgic patients.



The character of the food requires close very close attention. In general, it will be found that milk is one of the best ways in which to give nitrogenous and albuminoid food. The starchy foods are, as a rule, well borne, particularly as they do not require much gastric digestion, being digested as you know, by the salivary, intestinal and pancreatic fluids. At times, however, the starchy foods lead to the development of secondary acids in the stomach, in which case it becomes necessary to diminish the amount of starch allowed and increase the amount of skim-milk, the patient being practically placed on an exclusive milk diet for a certain length of time. Alkalies are often desirable, and lime-water mixed with milk is a convenient way of administering these.

I shall recommend for this man the following dietary :

**Breakfast.**—Soft-boiled egg, oatmeal, bread and butter, and milk with lime-water. Between breakfast and dinner, a glass of milk and lime-water.

**Dinner.**—Potatoes, bread and butter, and milk and lime-water, but no meat. Between dinner and supper, a glass of milk and lime-water.

**Supper.**—Mush and milk with milk and lime-water to drink.

In selecting the remedies to be associated with this diet, you will be governed by your appreciation of the state of the mucous membrane more than by anything else. If there is no evidence of gastric catarrh, if there is simply the hyperæsthetic neuralgia and anæmic condition of the stomach, iron, arsenic and belladonna may be given at once with confidence, the stomach being sheathed with bismuth taken at proper intervals after eating. Under such circumstances, a pill containing the following might be given : R. Quinæ sulph., gr. j. ; acidi arseniosi, gr.  $\frac{3}{16}$  ; pil. ferri carb., gr. j. ; ext. belladonnæ, gr.  $\frac{1}{16}$  ; M. et ft. pil. no. i. Sig.—To be taken after food, three times a day.

Any of the vegetable salts of iron may be substituted for the pill of the carbonate. In addition to this, ten grains of bismuth should be given two hours later to protect the stomach when most empty.

If there be a catarrhal condition of the mucous membrane, as shown by a coated tongue, distress in the stomach, in addition to the paroxysmal pain and evidences of dyspeptic trouble, we are obliged to adapt our remedies to this condition, postponing the use of anti-neuralgic remedies until the inflammation of the mucous membrane is relieved. In such cases bismuth with pepsin, dilute mineral acids, carbolic acid, and salts of silver become exceedingly valuable for their antacid, sedative, and alternative properties.

For this patient, having directed a careful diet with alkali, we shall order minute doses of nitrate of silver with belladonna.

Two weeks later, the patient reported much improved, and the pill of quinine, arsenious acid, and iron above given was substituted for the nitrate of silver, the same diet being continued.

## FOREIGN BODY IN THE PHARYNX.

Walter F. Atlee reports the following case in the *Med. Times* :

It is not at all an uncommon occurrence to have a visit from a patient who complains of having swallowed something that is still sticking in the throat. In almost every one of these cases there is no foreign body in the passage. Those patients have a local pain, in some cases the result of injury by a hard body hurriedly swallowed, and they are so entirely convinced by this sensation that a foreign body has lodged there that it is impossible to make them believe otherwise. The surgeon himself may make a mistake, and think he feels a something that ought not to be there. I heard even Nélaton say that in a certain case, after pushing his finger deeply into the pharynx, and feeling a small resisting body, he made several attempts to seize it with the forceps before discovering it to be the great horn of the hyoid bone.\*

I made observations somewhat similar to these to a man who came, in great excitement, on the evening of the 30th of last December, to take me to consult with a well-known and experienced physician in the northern part of the city in the case of a child in a dying condition from the presence in the throat of a pin, as the father protested, but which the doctor had not found and did not believe to be there. On the afternoon of Christmas day, five days before, the father said his child, just seventeen months old, most certainly had a pin in her mouth, that it had disappeared when he went to take it out, and the symptoms of throat trouble began at that time. For five days the child had taken food with great difficulty and reluctance, keeping the hands in the mouth as if striving to pull something from the throat.

It will here be called to mind that while more bulky objects generally become arrested at the junction of the pharynx with the œsophagus, where the tube is narrowest and least easily expandible, a thin and pointed body, such as a pin, generally sticks between one of the pillars of the fauces and the tonsil, or thereabouts. Again, when such a body stops in the pharynx, that which takes place is owing less to its size than to its shape: it is a body that, as a rule, cannot be pushed farther instead of being extracted, as is often done with bodies of another kind. *It must always be extracted.*

On reaching the house, the child was found ly-

\*See Clinical Lectures on Surgery, by M. Nélaton, p. 54.

ing in a cradle, on her left side, the head thrown back, in a state of stupor, from which she could be roused but very imperfectly. She had had during the day several convulsions. The lips were bluish, and the whole countenance extremely pale, with a bluish tinge. There was a swelling in the neck on the right side, which was the uppermost, below the mastoid process, posterior to the line of the ear. This swelling was not so hard as in cases of diphtheria: it had the feel of cellular tissue affected by acute oedema and not by phlegmonous inflammation. In the mouth was someropy mucus tinged with blood, but there was no repulsive odor. While examining these appearances it was suggested that the child had the mumps. There was no swelling, however, about the temporomaxillary articulation, nor anywhere anterior to the ear. It was posterior to the ear and inferior to the mastoid process. Moving the head, the left side of the neck presented a condition similar to that on the right, though not so marked.

The attending physician said his treatment had consisted mainly in the administration of the chlorate of potassa in a syrupy solution. He did not believe in their being any foreign body in the child's throat but was very willing to have search again made for it. When searching for it himself, he had made use of his eyesight only, and had never passed his fingers into the pharynx.

The child was taken up and held in the nurse's lap in a convenient position for the examination of the pharynx. The doing of this roused her somewhat, so that a few drops of chloroform were used to quiet her. The mouth was then opened, and the jaws kept apart by a large cork. Then the finger was passed into the throat a pin was encountered, firmly fixed there, and seemingly stuck, one end between the right tonsil and the pillars of the fauces and the other in the posterior wall of the pharynx. The extremity of the forefinger of the left hand being kept in contact with the pin as a guide, a dressing forceps was made use of; and on the second attempt to seize it, and with the use of some force and some manoeuvring to dislodge it, the pin was withdrawn. The pin was exactly an inch and three-sixteenths in length, and it was bent in the centre at an angle of about a hundred and twenty degrees. This bending could scarcely have been produced by the force used in extracting it from the throat.

As there was, of course, great difficulty, even impossibility, in making the movements of deglutition, and every attempt to swallow must excite reflex movements in the pharynx and retard cure, it was advised that no food or medicine should be given by the mouth. In order to try to nourish and stimulate the patient, appropriate enemata were ordered. The child, however, never revived, the stupor became more and more profound, and she died the following day,—just twenty-four

hours after the removal of the pin. The cause of the trouble, the source of the irritation, having been gotten rid of, hopes were entertained that the patient might recover, but, as is often the case in children when the exhaustion and the enfeeblement of the nerve centres have been so great that repeated convulsions are the result, she never again became conscious, and life gradually went out.

The history of this case teaches nothing new, but it is well at times to be reminded of what may occur, and of the extreme care and watchfulness that are at all times demanded in the practice of our profession, in order to avoid sad and even fatal mistakes.

## FRACTURE OF THE LOWER END OF THE RADIUS.

BY R. J. LEVIS, M.D., PHILADELPHIA.

The correct nature and mechanism of the ordinary form of fracture of the lower end of the radius is now, after much controversy, generally admitted and properly comprehended. With this proper understanding the indications of treatment become rational and decisive. In the usual and very characteristic fracture of the carpal end of the radius the primary line of the fracture is, with little tendency to deviation, *transverse* in direction. Associated lines of fracture are generally those of comminution of the lower fragment, and are caused by the upper fragment being driven vertically into it and splitting it, usually in directions towards its articular surface. The displacement of the lower fragment is towards the dorsal aspect of the forearm, and its articular surface is inclined in the same direction, abnormally presenting backwards and upwards.

The mechanism of the fracture is its production by falls upon the palm of the hand, which, with the carpus, undergoes extreme extension, and the fracture is caused by an *act of leverage* or *transverse strain*. This direction of force has also been called *cross-breaking strain*. In this fracture, actual displacement of the lower fragment may not exist at all, or it may be to the extent of complete separation from contact with the broken surfaces, varying with the amount of force applied and with the retaining influence of the surrounding dense structures.

The first essential of the treatment of fracture of the lower end of the radius is *the complete reduction of the displacement*. The action of replacement must be directed to the lower fragment itself. The reduction of the fracture can usually be thoroughly effected, under anæsthesia, by *strong extension applied to the hand, associated with forced flexion of the wrist, and with pressure applied directly on the dorsal surface of the lower fragment*. Unless vertical splitting or comminution of the lower fragment

exists, the maintaining of partial flexion of the wrist, with pressure of a pad on the dorsal surface of the fragment, will prevent return of deformity. With the object of retaining the apposition of the fractured surfaces, by overcoming displacing forces, I have practiced for many years on the principles involved in the splint here illustrated, the application of which will not require much description. In the treatment of fracture of the lower end of the radius it is essential that proper allowance be made for the curvature of the anterior or palmar surface of this part of the bone. This is insured in the splint which I have devised, which follows correctly the radial curvature; and the fixing of the thenar and hypothenar eminences of the hand in their moulded beds, maintains the splint immovably in its correct position with reference to the radial



curve. To neglect of complete primary reduction of the displacement of the lower fragment, and to inefficient restoration and retention of the normal radial curve, are due the frequent unfortunate sequences of this fracture.

The splint is made of copper, so as to be readily conformable by bending to suit the peculiarities of size and form of forearms. The slight roughness left on back of splint from perforations is for the purpose of keeping the bandage from slipping. It is nickel-plated to prevent oxidation. The splint will usually fit the forearm so accurately that but little padding will be required, and a piece of woven lint, or of cotton or woollen flannel is all that is necessary for its lining. No dorsal splint is needed, but, as before referred to, a small pad will, in most

cases, be required over the dorsal surface of the lower fragment. For retention of the splint an ordinary bandage, two inches and a half to three inches wide, is all that is necessary. This splint has the merits of being applicable to all cases of fracture of the lower end of the radius, and also to many other injuries involving the forearm and wrist, and, as now supplied, is very inexpensive. It is manufactured by J. Ellwood Lee, 435 Walnut Street, Philadelphia, Pa.

#### ERRORS IN THE DIAGNOSIS OF PREGNANCY.—

Professor Pajot, in a clinical lecture, observed that he wished to refer to a case which would prove of great value to the pupils, as putting them on their guard in relation to faults in the diagnosis of pregnancy. Such faults have been committed by men of the highest eminence, for in 95 cases out of the 100 diagnosis is quite easy, in some others it is attended with extraordinary difficulty. In this case, of recent occurrence, such a fault had been committed by men in a high position, one of them enjoying great celebrity. In place of hesitating to communicate the case Professor Pajot brings it prominently forward, as it exhibits the precise rule which should be observed on these difficult occasions, and may save the reputation of the practitioner and even the life of the patient. A lady, thirty-five years of age, had a child when she was twenty, after a laborious labor requiring the forceps, and followed by a vesico-vaginal fistula. Since then she has had two labors, both quite easy. After the last of these, eight years ago, she suffered greatly from menorrhagia; but having five years since begun to introduce a large sponge into the vagina, for the purpose of sustaining the uterus, which had descended considerably, and absorbing the urine from the vesico-vaginal fistula, the menorrhagia ceased and was succeeded by irregular and sparing menstruation. Having become a widow she re-married, and coition was always performed with the sponge at the bottom of the vagina. Last summer she consulted Professor Pajot because her abdomen had greatly enlarged and she wished to know whether she was pregnant. Having removed the sponge he proceeded to examine her, and found the perineum very lax and easily depressed, a small vesico-vaginal fistula still existing. The cervix, in the erect posture, descended to within a few centimetres of the vulva, and was flattened, small, hard, atrophied and colorless. The orifice was but slightly developed. The uterus rose largely out of the pelvis and was very mobile, but its oscillations were not communicated to the cervix. Professor Pajot delayed giving his opinion on the case for a fortnight, when the patient declared that she felt the child move; but the foetal heart could not be heard and the opinion was still withheld. Meanwhile an accoucheur and hospital surgeon was consulted, who, after an atten-

tive examination, declared that an ovarian cyst existed. This alarming the patient, a celebrated laparotomist was consulted, who stated that a large fibrous tumor of the uterus existed and advised an operation. Three weeks after this last consultation, the patient having taken some very violent purgatives, gave birth to a child between seven and eight months old, all traces of the tumor disappearing. "Faults like these are committed only because old counsels which I have long since delivered have been forgotten. In these difficult and obscure cases, I said there is a simple line of conduct to be followed, which is both useful and prudent, and never compromises the health or life of the patient nor the reputation of the practitioner. This is *expectation*; we must know how to wait. If there is some pressing indication, of course we must fulfil it; for, when life is menaced, what matter is it about the pregnancy? But, as a general rule, neither the health nor the life of the patient is in question. The woman desires to know whether she is or is not pregnant. And as long as the problem does not appear to be soluble with certainty we should make no resolutions. Let us wait, and above all things wait without acting, if nothing creates an absolute necessity for action. Time is the best of all our means of diagnosis."—*Press Med. Belge*, Sept. 7, 1884; *Med. Times*.

**FEVERS—GENERAL TREATMENT.**—Professor Da Costa gives the following general rules for the treatment of fevers:

1. Reduce the temperature. The cold bath will do this most rapidly and certainly, but it is troublesome, and not altogether free from danger, and should therefore only be used as a last resort. Quinine in full doses is safer, and may usually be relied upon. It should not, however, be repeated too often, as it may produce alarming cerebral symptoms, with diarrhoea and general perturbation.

2. Lessen the rapidity of the circulation. Aconite is the best remedy here, especially if the pulse is full and frequent, but if the circulation is weak, digitalis will act better. Professor Da Costa does not, however, often give either. He prefers to endeavor to reduce the temperature, and so indirectly to control the circulation.

3. Keep up the secretions. Remove the waste of the tissues by diuretics, diaphoretics, and laxatives.

4. Nourish the patient. "Don't starve a fever." Give milk, beef juice, and other light nutritious food in small quantities, but at frequent intervals. Give the patient plenty of fluids also. Slightly acidulated drinks will be found to be both grateful and beneficial.

Professor Da Costa's experience has been that typhoid-fever patients do better, as a rule, on the dilute nitro-muriatic-acid treatment than on any

other of the many that have been proposed. It controls the diarrhoea to some extent and aids digestion. He generally orders twenty drops of it to be taken every four hours in water or syrup. The circulation is to be sustained at the same time, and the heart's action steadied by the administration of quinine in tonic doses—gr. vi-x daily; or, better still, by alcohol in small and frequently repeated doses. If the discharges from the bowels exceed three a day, or if they are excessive in quantity, they must be lessened by opium or opium and bismuth; or if the stomach be irritable, by opium and carboic acid, or carboic acid and bismuth. If these remedies prove unavailing, a combination of nitrate of silver or sulphate of copper with opium will usually be found effective.

For the tympanites, Professor Da Costa recommends cold-water applications to the abdomen, injections of vinegar and water, or turpentine stupes externally, combined with the internal administration of ol. terebinthinæ gtt. v-x and morphinæ sulph., gr.  $\frac{1}{2}$  every two or three hours. The latter plan will be especially valuable if the tympanites co-exist with a dry, glazed and fissured tongue. The very high temperature that sometimes develops can be most safely and efficiently lowered by either the cold bath or by ice-water cloths on the abdomen.

The other complications are to be treated as they arise.—*Med. Bulletin*, January.

**COMPLETE ASPIRATION.**—David Christie, L. R. C. P. Ed., etc., Medical Officer of Rossquill Dispensary, writes:—

For some years past there has been much written regarding the use of the aspirator in cases of pleuritic effusion, and the talent displayed on this subject is creditable to the medical profession; but in using the aspirator there has been one thing omitted that mars or nearly destroys its utility. I have waited more than two years for some one to find it out, but, strange to say, in vain.

The thing is as simple as making an egg stand on its end *when you know it*, and the only mystery about it is that no one seems to have thought of it. I have tried partial aspiration as it is usually performed, and find that the pleural cavity refills in a short time; after complete aspiration it does not. The way it is managed is very safe and simple. I put a broad bandage round the chest that can be laced behind like a corset; then as I pump the fluid *out*, I press the ribs *in* by tightening the bandage. I think when I do so it is unnecessary for me to explain that I prevent any internal organ from being displaced (at the same time keeping them at a proper pressure), and the ribs by their elasticity from acting as a suction pump to cause a re-accumulation of fluid. I allow the bandage to remain on for some days. Any one who understands the action of a pump and a

syphon requires no further explanation. Many imagine they do, but are mistaken; these I would advise to consult "Ganot's Physics." After a certain amount of fluid has escaped, dragging pains set in. Tightening the bandage instantly gives relief. Alternate aspirating and lacing should be continued until all is removed; then there is likely to be a fit of spasmodic coughing; the patient may spit some frothy mucus tinged with blood, but all such symptoms pass off in a few minutes, and do not return—at least, that has been my experience.

I may add that the needle should be put in at such an angle that, after piercing the costal pleura, the point can be made to touch it again, so that when the pleuræ approach each other the lung may not be wounded; and when necessary the pleural cavity should be made antiseptically clean. *Med. Press*, Jan. 28th.

**TREATMENT OF BRONCHITIS—WOOD.**—It is not generally known that alkalies in large doses are amongst the most efficient of sedative expectorants. The citrate of potassium is much the most eligible for administering alkaline expectorants; of it half to one ounce should be given in 14 hours. The following prescription has been tested during four to five years, and found to be much the most reliable and sedative cough mixture that I have ever used:—R. Citrate of potash, one ounce; lemon-juice, two ounces; syrup of ipecac, half ounce; syrup enough for six ounces. Dose—Tablespoonful four to six times a day. When there is a good deal of cough or any excessive susceptibility of the bowels to loosening medicine, paregoric should be added in small quantity. The ipecac should be varied according to the susceptibility of the patient's stomach. Sometimes it can be advantageously substituted by tartar emetic. Usually two to three days of such medication will establish free expectoration. Then the stimulant expectorants are required, or squills and seneca, the former being the more valuable, though I cannot affirm that I have obtained positive results from their use, and think much of their reputation is based upon tradition and natural tendency of the disease to subside. Even squills is inferior to the mur. of ammonia. Like all ammoniacal preparations, this must be given at short intervals to maintain constancy of effect. The action of the single dose can scarcely last over two hours. Its acidity and disagreeableness may be somewhat covered by glycerine. In very large amounts all ammonia salts are capable of acting on the crisis of the blood as alkalies, and causing great vital depression. The value of copiba in chronic bronchitis has been long recognized, and it may sometimes be used with advantage in obstinate subacute bronchitis. When the "cold" in children is obstinate, "syrup of garlic" is very efficacious. But the stimulant expectorant which in my hands has almost replaced others of the class

is the oil of eucalyptus. It may be administered in ordinary cases of adults to the amount of about forty minims a day. Its taste is so pre-eminently disagreeable that it should be given in capsules, each of which may contain ten minims; or, if the patient prefer, two capsules of five minims each may be taken at a dose. The oil appears to be slowly absorbed and eliminated, so that four times a day is often enough. In emulsion it is very apt to cause unpleasant eructations, but in capsules is usually well-borne. Some stomachs will not tolerate it. Counter-irritation is very useful; the oil of amber, an old remedy, is especially valuable in young children who have so often marked nervous disturbances and a tendency to collapse, diluted with one to three parts of sweet oil, applied to chest upon saturated flannel; it sometimes acts very happily in allaying nervousness as well as internal congestion.—*Ther. Gaz.*

**VACUOLATION OF THE BRAIN.**—Dr. J. C. Shaw read a paper before the New York Neurological Society, Feb. 3, 1885, on this subject, and showed a specimen.

Dr. Peters stated that very interesting cases were to be found on record in the "Transactions of the Pathological Society of London."

Dr. Parsons had never seen vacuoles of the brain of the size of those shown in the specimen. He had seen smaller ones. His impression was in accordance with the views expressed in the paper with regard to the origin of the enlargement of these perivascular spaces.

Dr. Weber thought that the vacuoles in this brain might be connected with septic fever, which certainly must have taken place during the man's life. He was inclined to think that there might have been infarctions in the brain which might have something to do with such immense vacuoles. He wished to know if Dr. Shaw had examined the brain soon after death.

Dr. Shaw said that he had done so the next day. He had cut into the brain afterward and found these cavities. There was nothing on the outer surface of the brain to indicate them.

Dr. Weber asked if Dr. Shaw really believed the larger-sized ones to be real vacuoles.

Dr. Shaw said that he really did.

Dr. Weber then asked if vacuoles as large as these had ever before been seen by Dr. Shaw or by any one.

Dr. Shaw stated that no one had seen them so large. He had not, at all events. The largest he had ever seen were of the size of a small nut.

Dr. Weber stated that the largest he had ever seen were as large as a pea, drawn out. They were of the size of the smaller ones surrounding the large ones in the brain that had been shown. In this respect he considered the specimen unique.

Dr. Shaw said that the reason he had presented

it was because it was an extraordinary specimen ; a great many cases were reported where there were no vacuoles. This man had certainly been subject to septic trouble. Dr. Shaw asked if those cyst cavities were not due to hæmorrhage.

Dr. Weber thought that the man probably had septic pleurisy. There might have been emboli carried into the brain ; certainly there was septic matter coursing through the arteries. In the cases he had known of there had been no structural disease going on.

It had struck Dr. Shaw that possibly thrombosis might have taken place in some of the small vacuoles, and that a large number of them might have been blocked up in that manner. The explanation that the perivascular spaces had been dilated was not a very good explanation for cavities of such large size.—*N. Y. Med. Journal.*

**ADDISON'S DISEASE.**—The details of the post-mortem and the microscopical appearances in a case of Addison's disease are given by Professor Cacciola, of Padua. (*London Med. Record*, Jan 15, 1885.) The patient, a man-servant, thirty-five years of age, died a year and a half after the skin had begun to bronze. The discoloration, with muscular weakness, had steadily increased. Febrile attacks occurred from time to time, and the patient died in one, delirious and convulsed. After death, beyond a certain softness of the brain, the nervous system, including the brain, the spinal cord, and sympathetic nerve, was found absolutely normal. The semilunar ganglia and solar plexus especially were carefully examined. The suprarenal capsules, on the contrary, were greatly altered. They were enveloped in a mass of fat and fibrous tissue, closely adherent to them. Each capsule was about the size and shape of a hen's egg, and weighed about thirty-five grammes. On section, the organs were seen to consist of a thick fibrous capsule of lardaceous appearance and tendinous consistence, sending prolongations inward. Between these prolongations were caseous substance and calcareous masses. The fibrous capsule and septa consisted of a thick connective tissue, with accumulations of leucocytes in course of degeneration. The contents of the spaces between the septa were made up of albuminoid detritus and oil-globules. In the central portion of the fibrous mass the connective tissue was calcified. Schizomycetes were looked for without success, but it is especially mentioned that some fat globules looked like Koch's bacilli colored by Weigert's method. There was little noteworthy amongst the other pathological conditions. There was, however, engorgement of the lymphatic follicles and of the agminated glands of the intestinal mucous membrane. The kidneys also were enlarged.—*Boston Med. Journal.*

CAFFEINE AS A SUBSTITUTE FOR DIGITALIS.—

Dr. J. Stewart, in *Can. Med. and Surg. Journal*, says : In the form of a double salt, as natrobenzoate, its action may be summed up as follows :

1. It strengthens, slows and steadies a weak fast, and irregular heart.

2. It quickly acts as a diuretic in cardiac dropsy, owing to its power of (a) raising the blood-pressure, and (b) of stimulating the secreting structures of the kidneys.

3. It is of marked use in the same class of cases as digitalis is. It differs, however, from that drug, in the following particulars : (a) It is less powerful as a cardiac tonic ; (b) it is a more powerful and prompt diuretic, and for this reason it gives relief quicker from all the troublesome subjective symptoms of cardiac failure.

It is probable that results obtainable from neither of these drugs, when given singly, could be brought about if caffeine was given first and its effects kept up until the cumulative action of digitalis could be made manifest. By combining the power of digitalis with the rapidity of action of caffeine we may get the advantages of both drugs with little of the disadvantages of either. There is no published evidence relating to these points, however.

**Dose and mode of administration of Caffeine.** The dose of any of the double salts should not exceed thirty grains in the twenty-four hours, this quantity being equal to about twenty grains of the pure alkaloid. Usually half the above dose will answer all purposes. The double salts are prepared by Merck, of Darmstadt, but have not as yet found their way to this side of the Atlantic. They, however, can be prepared extemporaneously. The following formula contains in each tablespoonful about one gram (fifteen grains) of caffeine :

Caffeine.....	15.00 (gr. 230) ;
Benzoate of Soda....	15.00 (gr. 230) :
Water.....	250.00 (3vijj).

The doses of caffeine (two or three grains) usually ordered are quite inadequate to act either as diuretics or cardiac tonics.

**SO-CALLED SPECIFIC TREATMENT OF TYPHOID FEVER.**—Dr. J. W. Hawkins, *Kansas City Medical Record*, Feby, 1885, says : It is said by medical writers of the present day that there is no known specific treatment for typhoid fever. We are gravely told that "the abortive plan by the use of calomel is the only treatment that can be considered ætiological or casual." To this statement I respectfully demur. If calomel aborts the fever in fifteen to twenty days, the bromide-of-potassium treatment will do it in seven to ten days. The bromide of potassium is a medicine (unlike calomel) attended by no bad results, and upon it we can confidently rely. It may be given in any and all stages of the fever—first, second, third, fourth,



fifth or sixth week. If you see the patient on the first or last day of the fever, begin at once to administer the antidote—bromide of potassium. In the whole metasynergetic cycle of remedies for typhoid fever the bromide of potassium stands at the head. It accomplishes what no other known remedy has done, when properly administered. It usually arrests the fever in from seven to ten days after beginning its use. If the treatment is commenced at the beginning of the attack, five-grain doses administered every three hours during the day only, and repeated daily, will usually be sufficient. But if in the last stage, from fifteen to forty grains will sometimes be required. In the last stage of a very severe case, when death seemed almost inevitable, I gave more than two hundred grains in twenty-four hours, producing no gastric disturbance whatever. The patient recovered. Hence from this and other like cases I am led to believe that we have a specific for enteric fever.

The truth of this has since been verified in the treatment of ten additional cases, the fever in every case being arrested in from seven to ten days. I think I am not talking too forcibly when I say that bromide of potassium is as much a specific for typhoid fever as the sulphate of quinia is for (ague) intermittent fever.

**HOW TO SEE ONE'S OWN RETINAL VESSELS.**—Dr. Maher, of Sydney (*Australasian Med. Gazette*, Nov. '84), describes a new method by which this may be accomplished.

Standing a short distance (ten or twenty feet) from a light gas jet, in a dark room, and covering one eye, say the left, with the left hand, the observer takes between the forefinger and thumb of the right a strong convex lens, and holds it at about its focal distance in front of the right eye. Then, steadily gazing at the light through the centre of the lens, he shakes the lens rapidly backward and forward along its axis, or up and down or from side to side. After a few seconds the shadow of the fovea centralis appears in the axis of vision as a light yellow patch studded with dark coarse granules. Simultaneously the retinal vessels in the region of the yellow spot, including the finest capillaries, appear as dark cords against the yellow light. This appearance according to Dr. Maher, is not unlike plate 72 in the last edition of Nettleship's book on "Diseases of the Eye," except that the difference between the arteries and veins is not so marked, and that one gets a more extensive view, seeing the shadow of the retinal vessels as far as the optic disk. The outline of the shadow of the fovea centralis, which falls upon the most sensitive part of the retina, the yellow spot, is well defined, while the outline of the shadow of the optic disk cannot be distinctly seen, as it falls upon a much less sensitive part of the fundus. The shorter and more rapid the movements of the

lens, the sooner the shadows of the retinal vessels and fovea centralis appear, and the more distinctly are they seen.

Dr. Maher claims that this is a simple and easy way of demonstrating:

*First.*—That there are no blood-vessels in the fovea centralis.

*Second.*—That the structures in which the visual impulses originate must be behind the retinal vessels.

*Third.*—That the fovea centralis differs in structure from the other parts of the retina.—*Med. Record.*

**PHLEGMASIA DOLENS.**—It appears that notwithstanding the numerous works and discussions on phlegmasia alba dolens the subject has not yet been exhausted. Dr. Brun, of Paris, has just written a work on the subject which throws some new light on its symptomatology. He considers the disease under two forms. The first occurring as a malignant affection from the onset, and causing speedy death; the second appearing as incidental in the course of a general pathological condition. The first, or infectious form, has been well known since the time of Velpeau. The second form the author sub-divides into latent, common, and lymphangitic. The latent form comprises those cases of sudden death from dyspnoea in severe diseases and after childbirth, in which the autopsy shows venous thrombosis of the limb, from which the detached particles have been carried into the circulation and obstructed the pulmonary artery. The common form is passed over as it has been so often described. The lymphangitic form is described as presenting a bright rosy color, diffused pains, which disappear slowly, great increase in the temperature of the limb and long-persisting oedema. The complications are: periphlebitis, consecutive arteritis, gangrene, and especially pulmonary emboli. The author regards a pre-existing lesion of the vein as the pathogenic cause. It may be due to vitiated nutrition, cachexia, or some severe febrile condition. A part of his observations, however, show that the nervous system deserves a share of attention. The views advanced by other recent writers on this disease are also of interest. Dr. Esler reports in the *British Medical Journal*, September, 1884, two cases of phlegmasia dolens occurring on the right side of patients who had, during and after labor, lain continuously on the right side. Dr. Dill, of Belfast, believes that one position long maintained may have something to do with the affection, but holds that the over-tension of the system from hemorrhage and infection of the womb often induces it. Dr. Macartney, in the *Indian Medical Gazette*, of November, 1884, the case of a young soldier, who after suffering pain in the iliac fossa with obstinate constipation for ten days, during which time his temperature rose regularly



each evening, suddenly experienced a severe pain in the left groin and the limb began to swell, reaching nearly twice the size of the normal leg. The pain was excruciating and not relieved by hypodermics of morphia. The swelling was uniform, elastic, but not pitting on pressure, there was œdema about the ankle. After four days improvement began, but was very slow, the limb being powerless, and attempts to move it causing dull aching pain. The author regards the case as one of phlegmasia dolens differing in no essential point from the disease as it occurs in lying-in women. The obstinate constipation, with pain in the left iliac fossa appears to have been the exciting cause, just as pressure of the foetal head in this region, followed by pain and malaise, is believed to produce the disease in puerperal woman. Another case is mentioned as having occurred in the same hospital a short time before, in a man recovering from enteric fever.—*Med. Record.*

**PORTABLE ANTISEPTICS.**—Dr. T. E. Hayward, of Haydock, writes: Professor Lister has recently recommended as a portable antiseptic, a saturated solution of corrosive sublimate in glycerine; a fluid drachm of this solution being sufficient to convert about four pints of water into one in a hundred solution. The glycerine solution, doubtless, occupies a comparatively small bulk, and is readily mixed with water; but it is not very convenient to manipulate in measuring small quantities, and, if the bottle containing it should be broken, or become uncorked while being carried with other things, the result is unpleasant. A much more handy way of carrying the corrosive sublimate is to prepare powders, each containing ten grains of the salt and chloride of ammonium. One of these mixtures will dissolve in a little water in a few seconds; and, on diluting up to a pint, a solution is obtained of the strength of one to nine hundred and sixty. A few of these powders, wrapped round with gutta percha tissue to avoid deliquescence, can readily be carried in the pocket-case. The well known fact that ammonium chloride aids the solution of corrosive sublimate in water, renders the above suggestion so obvious that it has, doubtless, occurred to many; and it has probably already appeared in print. In view, however, of the very great advantage to all surgeons in country practice of having so ready a means of preparing an antiseptic solution, it may be pardoned if attention is drawn to the matter.—*British Med. Jour.*, Oct. 18, 1884.

**PHOSPHATIC CONCRETION OF THE BOWEL.**—Some weeks ago a young girl of about 18 years presented herself at Prof. Pancoast's clinic, with an opening in the abdominal walls on the right side, at a point near the middle of a line drawn from the umbilicus to the anterior superior spinous

process of the ileum. The history of the case developed the fact that the wound was the result of an injury received some four years ago, and that during this time more or less pus had been discharged through the sinus. The patient having been anesthetized and the wound slightly enlarged, it was found that the finger could be carried directly into the peritoneal cavity. This was rather an unexpected disclosure, and so antisepsis had not been provided for. Prof. Pancoast found upon a coil of small intestine a hard mass, which, upon removal and examination, proved to be a phosphatic concretion. The intestine was brought up to the mouth of the wound, a few bleeding orifices were secured by some fine black silk ligatures, and after all hemorrhage had ceased, the opening was dressed. The patient bore the operation remarkably well; on the second day a localized peritonitis set in, but this was soon controlled. The wound began to heal rapidly, except at its most dependent part. This occasioned the reopening of the parts, and another similar concretion was removed. From this time on the young woman did exceedingly well, the wound healing kindly, and before her discharge from the hospital she was presented to the class, apparently looking none the worse for the operation and her consequent protracted stay in the hospital.—*Col. & Clin Record.*

**TRACHEOTOMY WITHOUT A TUBE.**—The danger and inconvenience connected with the tracheotomy-tube *per se*, are sufficiently great to have aroused a desire for some device which would obviate them. The matter was the subject of discussion before a late meeting of the Philadelphia Academy of Medicine. Dr. J. B. Roberts said he had had so much difficulty in keeping the tube clear that he had discarded it entirely, and instead cut out a rectangular piece of the trachea and stitched the edge of the opening to the skin. He found this to answer better than the double canula which is liable to become choked with the secretion. Dr. Packard had operated in this manner, but feared to adopt it as a general rule lest constriction of the trachea occur through cicatrization of the opening on healing. He instanced one case in which this had occurred. He thought the testimony in favor of tracheotomy without a tube was, however, very strong. Dr. J. H. Brinton recalled two cases in which the tube had been dispensed with. The membrane was readily ejected, and there was far less trouble than from the tube. Both cases, however, died from diphtheritic infection. Dr. Nancrede regarded the danger from ulceration from the irritation of the tube as sufficiently great to warrant the adoption of such a substitute for it as had been suggested, and the sentiment of the meeting was in favor of according a trial to the method of performing tracheotomy

which should dispense with the canula.—*Med. Age*, Jan. 10th.—*Analectic*.

**ACUTE BRIGHT'S DISEASE.**—In Professor A. L. Loomis recent treatise on "Practical Medicine," the author reviews the subject of treatment by diaphoretics and hydragogue cathartics. He states that he has been convinced for some years that the depurative method was wrong, and gives as the three indications: the elimination of urea and its allies, the removal of inflammatory products from the tubules, and the counteraction of the effect of urea and its waste products upon the nervous system. For this purpose the patient is put to bed, frequent dry cups are applied over the loins, and infusion of digitalis is given internally. This may be supplemented with acetate of potassium, spirits of nitrous ether, or some other mild diuretic. The bowels are of course kept open, and the skin moist. If severe uræmic symptoms appear, hydragogue cathartics and hot-air baths may be temporarily resorted to. Milk should be the only article of diet, and water is the best diuretic.

The view taken as to the utility of digitalis and the potash salts in nephritis, is sustained by the clinical experience of nearly all English observers from the time of Bright.—*N. Y. Med. Record*, January 3rd.

**LANCING CHILDREN'S GUMS.**—In the discussion of this subject before the Medical Society of London, Mr. Hamilton Cartwright (dentist) was distinctly of opinion that both diarrhoea and convulsions might be caused by dentition. There were two conditions under which lancing the gums is indicated: 1. If the gum is tense and glistening at the epoch when the tooth is about to come forward, by cutting into the sac of the tooth great and immediate relief is afforded. 2. In an inflammatory condition of the gums with tumidity, but without the extreme tension of the first class of cases, incision gives relief. In the latter class of cases the treatment is empirical but none the less successful.

Dr. C. J. Hare said it was to him a matter of great surprise and regret that the profession should so blindly give way to fashion as it had done on many points. Hundreds of lives had been lost by abandoning the use of bleeding; and among the forms of bleeding, the practice of lancing the gums, that is, bleeding from the gums, is one that deserves to be revived or continued. Dr. Webb had seen so many children on the point of death saved by lancing the gums that he regards it as a most valuable method of treatment.—*Mid. Med. Four.*, Jan. 31st.

**HINTS ON THE USE OF DRAINAGE TUBES.**—In the *Journal of the American Medical Association*, Jan. 3rd, 1885, Dr. H. I. Getz, of Marshalltown, Iowa says:—"Some months ago we had occasion

to evacuate a pelvic abscess, and use a drainage tube for through drainage. Not having at hand at the time a regular drainage tube, we constructed one out of a piece of plain (small size) rubber tubing. After being in the opening for several days, we desired to replace it by another tube; we attempted to remove it; but found that the openings in the tissues through which the tube had passed, had contracted so as to hold tightly the tube, and although we made but slight traction, anticipating the possibility of the tube's breaking, to our extreme discomfort and dissatisfaction we soon realized that our anticipations were realities, a portion of the tube, an inch in length, remaining within the pelvic cavity.

We succeeded in removing it by dilating the opening through which the tube passed; then introducing a small blunt hook, we succeeded in drawing the piece of tube into position, so that it was easily grasped by a pair of forceps and extracted, much to our satisfaction, and with a vow that in the future we shall *select with caution our material for drainage tubes*.

A hint on the removal of tubes, and also upon their introduction, may not be out of place here; under circumstances as above described where the tissues firmly hold the tube, we should adopt the plan of inserting within the tube a dilator of some kind, with which to dilate the tissues before we attempt to withdraw the tube.

As a satisfactory method of introducing drainage tubes, we have found that where a trocar-canula was necessary to evacuate the contents of a cyst or an abscess, by taking the precaution to use a canula a trifle larger than the drainage tube to be used, the latter could be conveniently passed through the canula to position, and then the canula withdrawn.

**PARALYSIS FOLLOWING HYPODERMIC INJECTIONS OF ETHER.**—Arnozin ("Gaz. hebdomadaire de médecine et de chirurgie") contributes a long article on this subject, in which he cites a number of interesting cases. In several instances in which injections were made under the skin of the posterior aspect of the forearm, paralysis of the extensors was noted within a few minutes. Under the use of the constant current the condition eventually disappeared. In one case a deep injection into the thigh was immediately followed by darting pains, which persisted for two weeks. The leg became livid, and wasted away, and the reaction of degeneration was observed. The patient subsequently developed a trophic ulcer on the heel, and improved very slowly, though under treatment for a year. The writer thinks that the phenomena described are really symptomatic of neuritis, which is due to the irritating action of the ether that has been deposited in the neighborhood of the nerve. [It is to be hoped that the publication of these will lead to more caution in those who are accus-

tomed to resort freely to hypodermic injections of ether, brandy, and even ammonia, in cases of collapse.] Ed.

**TREATMENT OF NASAL POLYPI.**—Dr. Richardson, in the *Asclepiad*, recommends the use of sodium ethylate in the treatment of nasal polypus. The caustic agent is applied by means of a probe made of soft cotton-wool, twisted into shape on the points of a pair of forceps. The cotton probe is saturated with the ethylate, and then plunged into the substance of the polypus. On removing the cotton it commonly happens that the patient can expel the whole mass of destroyed polypus in a semi-fluid form, by blowing the nose sharply. A second application ought to be made with a view of destroying the base of the polypus. The mode of action is said to be sufficiently clear. The ethylate is decomposed by contact with the water of the polypus into caustic soda and alcohol; the latter coagulates the albuminoids, and the former acts as a powerful caustic. With the exception of some burning pain, no unpleasant effects seem to follow the use of this method.—*Weekly Medical Review*, February 28, 1885.

**LAPAROTOMY FOR GUN-SHOT WOUND.**—The first successful case of laparotomy for gun-shot wound done in this country, and the second on record, is reported in the *New York Med. Journal*, of Feb. 14, by Dr. W. T. Bull. A man shot in the abdomen by a bullet from a revolver (caliber No. 32), was admitted into the Chambers St. Hospital, New York, where, twelve hours after the accident, Dr. Bull saw him. The wound was situated at a point an inch and a half below the navel, and an inch and a half to the left of the median line. Seventeen hours after, having convinced himself by probing the wound that the bullet had entered the abdomen, Dr. Bull made a median incision through the abdominal wall. The gut presented, and on careful examination seven perforations were found. These were all closed with silk sutures. The search was continued, and the bullet was at last found lodged in the wall of the sigmoid flexure. The wound in the abdomen was closed after the cavity had been thoroughly cleansed with a solution of carbolic acid (two and a half per cent). As a preliminary to the operation carbolic acid by means of the spray was diffused through the room, in which was maintained a temperature of 80° F. All solutions were used warm.—*Med. Review*.

**EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.**—Dr. Guttierrez reports this curious case in *El Diceamen (Le Progrès Medical)*. A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a foetal head. Capillary puncture gave a clear fluid con-

taining numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any suppuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally the skin, using Lister's dressings. There was not the slightest trace of peritonitis, the reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal.—*Four. Am. Med. Association*.

**IODOFORM IN THE TREATMENT OF COMPOUND FRACTURES.**—Bach (Inaug.-Diss, "Centralbl. f. Chir.") speaks highly of the direct application of powdered iodoform to open fractures. The powder is sprinkled upon salicylic cotton, and placed over the wound. Over this is applied a quantity of iodoform gauze, and the whole is secured with a plaster-of-Paris bandage. Of twenty-eight cases which were thus treated, sixteen ended in perfect recovery. The bandages were not disturbed during the entire process of healing. In another series of twenty cases, twelve were cured. The writer arrives at the conclusion that the treatment with "iodoform-sca'bbing" (*Iodoformschorftherapie*) without drainage, is to be recommended in all cases of compound fracture in which the laceration of the soft parts is not too extensive. A neglected wound, in which there are numerous pockets filled with pus, is a contra-indication to this method of procedure.—*N. Y. Med. Journal*.

**ERGOT AS A MEANS OF DIAGNOSIS.**—Dr. J. W. Elliott in reporting five cases of ovariectomy in the *Boston Medical and Surgical Journal*, January 29, notes a use of ergot, which seems original with him. There was a very large immovable tumor, larger than a hen's egg, in the hollow of the sacrum somewhat to the right side. The uterus was three and a half inches deep and in left lateral reversion. The tumor and uterus seemed blended into one mass. It was very difficult to determine what the tumor was and to what it was attached. To assist in determining this point Dr. Elliott administered ergotin pills until the uterus became fully and firmly contracted, when he found

that organ harder than the tumor and of decidedly different consistency, from which he was led to conclude that the tumor was not growing from the uterus, but only crowded against it.—*Med. Review.*

**FOLLICULAR PHARYNGITIS.**—E. S. Billings, M.D., writes: Will you please inform me through the columns of *The Monthly* what I shall do for an old case of follicular pharyngitis? It is one of the most obstinate cases I have ever dealt with, and I have exhausted all the means I know of, and oblige.

[Wipe the diseased surfaces well with a solution of bicarbonate of soda, three drachms to the ounce of water. After this is thoroughly done, removing all the secretions, spray it well with a solution of nitrate of silver, from twenty to forty grains to the ounce of water. This should be repeated once or twice a week as the indications call for. As a rule we have no trouble in curing the cases we have met with in this manner.—ED]—*New Eng. Med. Mo.*, Jan.

**CARBONATE OF AMMONIA IN SCARLET FEVER.** Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*Med. Record.*

**PIN SWALLOWING.**—In the *New York Medical Record* of Jan. 15th, 1885, I noticed an article on "Pin Swallowing." I paid very little attention to it, as the case was treated contrary to my teachings. On Feb. 2nd, about 4.30 p.m., Mr. G. H. E. came to my office in a great hurry and stated that his daughter Nettie, about 8 years old, had swallowed a large shawl pin. She placed the pin in her mouth to arrange the shawl around the shoulders, and while doing this threw back her head and down went the pin. I told him I was taught to give a brisk cathartic in such cases, but I believed it better to give plenty of bulky food, as I had read an article to that effect not long ago in some journal. He told me the child lived almost exclusively on bread, of which she ate enormously. I advised him to give plenty of food, no purgatives, and watch the stools. The pin was swallowed

February 2nd, 4 p.m.; evacuated in the centre of a mass of feces February 4th, 2 p.m., forty-six hours afterward. It measured  $2\frac{3}{8}$  inches in length, with very sharp point, and a glass head somewhat larger than a buckshot. It passed away as it entered the mouth, head first.—*Dr. Wagner, in Col. & Clin. Record*

**DANGER OF DIPHTHERIA CONTAGION.**—Prof. Jacobi, (*New York Med. Journal*) says that many sore throats regarded as trivial are, in point of fact, diphtheria; especially those known as follicular tonsillitis. What to-day looks like one or more points covering the outlet of ducts, to-morrow may be a continuous membrane. Some mild cases of diphtheria are prolific of danger because they are apt to assume a chronic course without losing contagiousness. The throats of servants, nurses, and others who are in constant contact with the children of a household or school, should be from time to time inspected. There is as much diphtheria out of bed as in it; nearly as much out of doors as in-doors. Diphtheria is contagious, and probably has no spontaneous origin.

**INJECTIONS OF ETHER AND IODOFORM IN COLD ABSCESS.**—Professor Verneuil obtains a rapid cure in almost all his cases of cold abscess, abscess from diseased bone or from congestion, etc., by ethereal injections of iodoform of the strength of one in twenty. The abscess is first emptied by means of Potain's aspirator, and then receives from 100 to 300 grammes of the iodoform solution. By not exceeding this quantity (*i.e.*, five to fifteen grammes of iodoform) no fear of accidents need be felt. The liquid penetrates into all the anfractuosités and diverticula of the abscess, the ether becoming absorbed or evaporated, and the antiseptic agent being deposited uniformly on the pyogenic membrane, the action of which it modifies. This simple means, so exempt from danger and for ease of applications has proved highly successful, very large abscesses having yielded to three or four injections.—*Revue de Thérapeutique*, August 15, 1884.

**SAVE THE FINGERS.**—Dr. William D. Ronaldson of Philadelphia, writing to us on the subject of conservative surgery, reports two cases which show it is often better not to yield to the impulse to cut off a bad-looking finger. A. B., a brakeman on a railroad train, had his finger caught between the bumpers of the cars while endeavoring to couple them. The nail and flesh were torn completely off, leaving the distal extremity of the bone exposed. The injury was of such a nature that amputation of the ungual phalanx would have been permissible; but having cleansed the wound thoroughly with tepid water, a dressing of carbolic oil (1 to 15) and cosmoline was applied. The finger healed in three weeks, and, except for the loss of the nail,

was as serviceable as before. The second case was similar to this one, in treatment and results.—*Medical Record, Feb. 14th, 1885.*

**IDIOPATHIC ANÆMIA.**—A favorite prescription of Prof. DaCosta in marked idiopathic anæmia is :

R. Ferri sulph. . . . . 5 j.  
Potassii carb. . . . . 3 j. M.  
Ft. pil. No. xl.

Sig.—One after meals for first week ; increase dose in second week, etc.

If the patient is a female suspend treatment during menstruation.—*Col. and Clinical Record, January.*

**ALCOHOL IN THE TREATMENT OF INSANITY.**—Dr. W. B. Fletcher, Superintendent of the Indiana Hospital for the Insane, and Dr. R. M. Bucke, of the London, Ontario, Asylum have entirely abandoned the use of alcohol in any form in the treatment of the insane. They believe that their patients do just as well as before, and perhaps better.—*Med. Record.*

**HIMROD'S ASTHMA CURE.**—Dr. A. J. Canpbell writes in the *Brit. Med. Journal* : "In Martindale's *Extra Pharmacopœia* there is an excellent substitute for Himrod's asthma cure, which I have tried and found very useful. Dissolve two ounces of nitrate of potassium in two ounces each of lobelia, stramonium leaves, and black tea well powdered ; mix well and dry thoroughly. A tea-spoonful burned, and the fumes inhaled, generally gives immediate relief."

**AN APPLICATION FOR OZÆNA.**—The following is Vidal's formula, as employed at the Hôpital St. Louis ("Jour. de med. et de chir. prat." ; "Practitioner") :

Solution of chloride of zinc, 5 per cent. . . 1 ounce ;  
Boric acid . . . . . 14 grains ;  
Water . . . . . 28 ounces ;  
Ammonia-water, enough to neutralize the solution.

**FORMULÆ.**—Prof. Bartholow has frequently prescribed the oil of wintergreen in rheumatism, with excellent results. A useful combination is :

R. Ol. gaultheriæ . . . . . 3 j  
Acidi salicylici . . . . . ʒ iv  
Sodii biborat. . . . . 3 j  
Syrup picis liquidæ,  
Aque anisi . . . . . aa f 3 ij M.

Sig.—Dessertspoonful every four hours.

In chronic bronchitis with asthmatic breathing, Professor Bartholow prescribes, in the clinic :

R. Ext. grindeliæ fluidi . . . . .  
Ext. quebracho fluidi . . . aa ʒ xx  
Ammonii iodidi . . . . . gr. v. M.

As a tonic in the asthenic type of fevers Prof. Gross advises the following :

R. Quiniæ sulphat. . . . . gr. ij  
Tinct. ferri chloridi . . . . .  
Acid. hydrochlor. dilut. . aa gtt. xv  
Tinct. nucis vomicæ . . . . . gtt. x  
Syr. zingiberis . . . . . f 3 ij. M.

Sig.—This amount ter die,

Instead of nux vomica  $\frac{1}{40}$  grain of strychniæ sulphas may be employed.—*Col. & Clin. Record.*

In lymphadenoma, following scarlet fever, in a girl of seventeen years, Prof. Da Costa prescribed

R. Acidi arseniosi . . . . . gr.  $\frac{1}{40}$   
Ferri sulph. . . . . gr. ij M.

Sig.—The pill ter die.

Over the enlarged glands rub :

R. Ung. iodi . . . . .  
Ung. belladonnæ . . . . . aa 3 ss.  
Camphoræ . . . . . gr. v. M.

In atonic dyspepsia, Professor Da Costa prescribed.

R. Tinct. nucis vomicæ . . . . . gtt. x  
Tinct. capsici . . . . . gt. j  
Tinct. cinchonæ comp. . . . . f 3 j M.

Sig.—Ter die.

To this was added pepsin, gr. iij-v, with each meal.

**DR. OSLER'S GULSTONIAN LECTURES.**—This year's lenten lectures at the Royal College of Physicians, London, were opened on Thursday, February 26th, by Dr. Osler, of Philadelphia, who choose for the subject of his Gulstonian Lectures the fascinating disease known as ulcerative endocarditis. His first lecture was devoted to the naked eye and microscopic pathology of the affection, its clinical history and etiology being left for discussion in the lectures to be delivered on Tuesday and Thursday in the following week. The lecture was mainly *ex tempore*, lasted the ideal forty-five minutes, and was unusually well attended. Dr. Osler, as might have been expected, was most cordially greeted, and there can be no doubt that his lecture was such as was well worth while his coming across the water to deliver.—*London Medical Times, February 28, 1885.*

**KAIRIN.**—Kairin, although comparatively little used as an antipyretic, has grown in favor particularly in France and to some extent in Germany. Its use has been more general in febrile diseases. Having been satisfactorily employed in pneumonia, scarlatina, measles, erysipelas, septicæmia, peritonitis, etc., it is considered a safe and valuable antipyretic, worthy of further trial. The usual dose of sulphate of kairin is about eight or ten grains every two hours till the temperature is reduced.

# THE CANADA LANCET.

A Monthly Journal of Medical and Surgical Science  
Criticism and News.

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the Editor Canada Lancet, Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MARLER, 23 Rue Richer, Paris.

TORONTO, APRIL, 1885.

*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## LACERATION OF THE PERINEUM.

A good deal, no doubt, of what even the most gifted medical journalist feels called upon to say is very stale and incipient to some of his readers. In this connection it is always well to remember that all are not specialists, nor have all reached the acme of universal medical knowledge. Moreover the bulk of the profession is scattered over the face of the country, far away from the centres of learning and concrete mental activity. What may be stale, and even incipient, to the college professor or hospital physician may be interesting and profitable reading to the general practitioner. Besides, the journalist does not pretend to write for the benefit of the specialist, or the few, but for his readers as a whole. This is our apology for referring to so common-place a subject as laceration of the female perineum.

The race of obstetricians just passing away gave themselves but little trouble or anxiety about the perineum. A partial rupture was regarded as of small consequence, while a more extensive one—if not complete, however deplored, yet was a thing to be patiently endured. Indeed, there is good ground for the belief that ruptures, both great and small, were not uncommon, all unknown to the learned attendant. Nor is it certain that even extensive lacerations do not occur without the knowledge of the supposed accomplished obstetrician of the present day. The former had some excuse for his lack of watchfulness, but the latter,

who is constantly admonished from every side, is scarcely able to furnish a valid excuse for his carelessness. Without doubt, lacerations of the perineum are becoming more frequent. It is not enough to say that, in the present day, cases which formerly were undetected, or, if detected, were not reported, are now more frequently discovered and made known, both to the patient and the profession. That is quite true, but, in addition, we know full well that artificial causes operate more extensively than formerly in producing this accident. The forceps is a great boon to woman and no one would abolish it, yet it is to its more common use that we must attribute the increased frequency, and often the more aggravated nature of perineal laceration. Of course, the perineum may be, and often is, torn by the natural efforts alone. Most of us have often been consulted by some old woman suffering, all unconsciously, from an ancient rupture of the perineum. She complains of falling of the womb, difficulty in making water, some kind of trouble about the lower bowel, besides a score of other troubles, but is utterly oblivious as to the real cause of all her suffering. Yet such a one might never have been delivered with forceps, and sustained the injury without any instrumental or undue interference.

No one will deny that the use of the forceps tends to greater liability to rupture. This arises from three causes at least. The first is the tendency under the excitement, and demoralization of the moment perhaps, to deliver too rapidly; secondly, delivery of the head while still grasped by the forceps; and thirdly, slipping of the instrument. Someone may be ready to exclaim that all these causes are avoidable. We think the experience of the most skilful contradicts such a position, and that the perineum will sometimes be ruptured while the forceps are held by the most "cunning" of hands. Rapid distension may be called for, or the tissues may have but little cohesion; uterine effort may be feeble or extinct, and the head may have to be delivered contrary to general rule, still grasped by the forceps; and a contracted pelvis, or a large, unyielding head, may render accurate manipulation impossible, and so cause a slipping of the instrument, an accident, of course, not always, though sometimes, followed by laceration. Few practitioners of extended experience, we feel convinced, but have had occasion to lament more

than once the presence of laceration, more or less serious, after a forceps delivery. Even Professor Goodell is not above confessing that such a casualty has occurred in his hands on several occasions. These remarks are not made in the interest of bunglers, but rather to make good the statement that the more frequent use of the forceps tends inevitably and unavoidably to an increase in the occurrence of the accident under consideration. After making due allowance for unavoidable cases, there is much room for the belief that a good deal of suffering is inflicted by the unskilful use of the forceps. It is manifestly the bounden duty of every obstetrician to study to maintain a cool head, a steady hand, and an avoidance of all the causes known to lead to this untoward accident.

When laceration occurs, as occur it will now and again, no one in his senses will leave the woman to her fate, that is, if the laceration be at all serious. The train of evil consequences following a considerable perineal rupture outstrips by far the consequences of an equal breach of continuity of tissue, not associated with the vital organs, in any other part of the body. Prolapse of the uterus, vesical and rectal protrusion, unhealthy vaginal and uterine discharges, erosions of the cervix and other uterine complications, difficult micturition, constipation, besides a host of general troubles, as neuralgia and indigestion, having their seat in reflex action, are a train of evils of so aggravated a nature as to call for the prompt execution of the measures best calculated to ward them off. The safest, best and only treatment, is the restoration of the part. Immediate closure of the breach is now insisted upon by the profession everywhere. For this several cogent reasons may be advanced. Delay in closing the wound exposes the patient to blood-poisoning; experience shows that the primary operation carefully performed is almost always successful; the primary operation is comparatively easy, and can be readily performed, when necessary, without the aid of a skilled assistant. In the secondary operation the necessary dissection is the most painful and delicate part of the work; in the primary operation nothing of this kind is called for; the parts are simply brought into their natural place and held there by approved supports. Lately new methods have been proposed but the quilled suture still holds its place for all extensive rents. In slight rents a single simple suture is all that is re-

quired. Dr. Alloway, of Montreal, first recommended the single suture operation in all cases we believe, not involving the sphincter or bowel. Perfect coaptation is the great secret of success in union by first intention, in all wounds, and nowhere is this more true than in wounds of the perineum. The after treatment of these cases is of great consequence. The wound must be carefully guarded against the action of the urine and lochia, and some approved antiseptic should be used, not only as an application to the wound but also as an injection. The conclusion of the whole matter is, that the obstetrician of the present day must be on the alert for perineal rupture, and be prepared to repair it on the instant when it occurs.

### SANITARY INSPECTION.

The history, character and progress of former epidemics of cholera in Europe point to the probability of an invasion of the disease in this country during the coming summer. It is therefore high time for the authorities to be aroused to the necessity of adopting such means as will prevent its incursion or mitigate its severity should it unfortunately reach our shores. The State Board of health for Illinois, in view of the expected invasion, has ordered a sanitary survey of the State and a house to house inspection, so that all sanitary defects and evils may be corrected as expeditiously and with as little expense as possible. The inspectors are authorized to request the prompt correction of all defects, and the removal of all nuisances as soon as they are discovered, and all persons neglecting or refusing to comply with the request shall be prosecuted according to law. The inspection will be conducted under the supervision of the health authorities wherever such exist, and where there is no such organization a health officer shall be appointed.

This action of the Illinois board is worthy of imitation, and we trust that immediate action will be taken by the authorities in our own city and elsewhere in the Dominion. It is important that this work be begun as soon as the weather will permit; *and it is especially desirable that certain details be attended to at the earliest practicable moment.* For example the emptying, disinfecting, filling with clean earth, or other necessary treatment of privy vaults, should be completed before warm weather



comes to interfere with such work, or before the appearance of a case of cholera makes it dangerous to attempt it. To this end, wherever the conditions make such action necessary, a proclamation or health notice should be issued, directing the immediate prosecution of such work.

### THE ONTARIO ANATOMY ACT.

The bill before the Legislature of Ontario bids fair to become law, and we trust that no unforeseen circumstance will arise to prevent its passing in the shape in which it was amended by the special committee to which it was referred. The bill is in Dr. Baxter's hands, and we have every reason to believe that no serious opposition will be raised against its provisions when it reaches the third reading. There is very great need of such a measure; the supply of material obtained under the old act was wholly inadequate to the demand. The number of medical students has greatly increased while the amount of anatomical material remained about the same; during the past session the supply was wholly insufficient, and the teaching of practical anatomy was greatly retarded in consequence. The Act provides that the bodies of those found dead, or dying in public institutions, (Lunatic Asylums excepted), and not claimed by relatives, or friends who are willing to bear the funeral expenses, shall be handed over to the medical schools for anatomical purposes. This is the essential clause, and if passed, will, it is confidently believed, give an abundant supply of material. The remaining clauses provide for the appointment of inspectors and in a general way secure the machinery for the proper working of the Act.

"UNPROFESSIONAL" ADVERTISING.—An epidemic of diphtheria in Halifax, N.S., is made the occasion for a fresh outbreak of "unprofessional" advertising among our confreres down by the sea. A disgusted M.D. writes to the *Halifax Mail* in regard to the matter in the following terms:—"I was surprised to see by your issue of last night that this serious question has begun to be made a pretext for puff and quack advertisements by some few of our medical brethren in this city. This action on their part is reprehensible in the extreme, and most derogatory to our profession, and would not be tolerated

in England, or elsewhere in this country; it is also most prejudicial to the matter under consideration and the public good. All praise is due to Dr. Campbell for the stand he has taken in ventilating this important subject, but the same cannot be said respecting others, who are too palpably endeavoring to foist their names before the public in this irregular manner; and it is to be hoped that the press of Halifax will not prostitute their columns by allowing them to be channels for this discreditable system of spurious medical advertisement. It was only very lately that the leading medical journal of Canada had occasion to censure severely one or two medical men in this province for a similar offence, and it is to be sincerely hoped that this stain on our profession in these parts is not about to be increased by a repetition of these improper and unprofessional practices."

PNEUMONIC FEVER.—In an article on relapsing or intermittent pneumonia in the "British Medical Journal" of recent date by Sir Andrew Clark it is said: "Every one appears to have asked if pneumonia is not a fever, but scarcely any one has asked if pneumonia is really an inflammation." In this connection Andrew Clark refers to a Lecture delivered by himself at the College of Physicians in 1866. These views were long since advanced by Professor Austin Flint, of New York, and are still held by him in his valuable work on the practice of medicine. He says that pneumonia is the local manifestation of a fever, and should be called "pneumonic fever." He gives the following reasons, with others, for the belief that it is a fever: The large quantity of exudation which is derived from the pulmonary artery—hence from carbonized and not from oxygenated blood—this exudation being ultimately completely absorbed, the air-cells returning to their normal condition. Moreover, pneumonia is never caused by the extension of any local process, such as abscess, gangrene, or any kind of local injury. Again, the disease is ushered in by a distinct rigor, and the temperature rises rapidly before there are any local manifestations. The spleen often becomes enlarged, and the patient becomes jaundiced.

MEDICAL JOURNAL ADDRESSES.—We have just received from the Illustrated Medical Journal Co., of Detroit, Michigan, several sets of their perfo-

rated, adhesive medical journal labels. The list includes besides the journals of the United States that are devoted to medicine, pharmacy and hygiene, those of the Provinces of Canada as well. Four complete sets will be mailed postpaid for fifty cents, on addressing the publishers above named. They are just what every physician needs for addressing his reprints for journal notice, and medical colleges for addressing their announcements for a similar purpose.

**HYPOSULPHITE OF SODA AS A DISINFECTANT.**—The difficulty of finding a satisfactory disinfectant with which to destroy fœtor in cases of cancerous ulcers, is well known. We have used a saturated solution of hyposulphite of soda added to an equal quantity of water, and found it exceedingly efficacious. The ulcerating surface was well syringed and washed with the solution, and was then covered with rags steeped in the solution. The granulations were kept clean, and the fœtor was well kept under. It is cleanly, has no smell, does not stain, and is not expensive.

**CLIMATE OF COLORADO.**—Dr. R. B. Teller of Aspen, Colorado, writes that the climate and mineral waters of Glenwood and vicinity are exceedingly well adapted to the cure of rheumatism and phthisis. Phthisical patients have been benefited to an extent that would seem perfectly incredible to those not familiar with the climate. Persons suffering from either of the above diseases, or with asthmatic affections, he says, may rely upon obtaining certain relief in Colorado.

**HALIFAX MEDICAL SOCIETY.**—A meeting of the medical profession of Halifax, N.S., was held on the 14th ult., to organize a medical society. After some discussion the following officers were elected for the ensuing year:—President, Hon. Dr. Parker; Vice do. Dr. Rigby; Secretary-Treas. Dr. Lathern; Committee on by-laws, Drs. Cowie, Rigby and Campbell; Executive Committee, Drs. Tobin, Cowie, Farrell, Almon, Wickwire.

**THE TREATMENT OF RINGWORM.**—Mr. Alden Smith, in the "British Medical Journal," speaks very highly of a solution of chrysophanic acid in chloroform for the cure of ringworm. The chloroform will dissolve the fatty matter in the hair follicles, thus facilitating the acid in getting to the

parasite, which it destroys. The prescription is used in the strength of seven grains of the acid to the ounce of chloroform. The hair, if there be any to speak of, should be closely clipped.

**NIGHT COUGH IN CHILDREN.**—The occurrence of a troublesome night cough in children is met with frequently. Dr. McCoy, of Philadelphia, in an article in the *Med. News* draws attention to this affection and claims that it is due in most cases to nasal catarrh with its accompanying secretion, etc. During the day the discharge passes away, but during the night it accumulates and causes irritation, or passes down the posterior nares and into the pharynx. The treatment recommended is to cleanse the nose before the child is put to bed by means of a spray composed of an aqueous solution of an alkali.

**LOCAL ANÆSTHESIA.**—It is said upon good authority that local anæsthesia may be readily produced by applying with a camel's hair brush the following mixture:

R Chloral,  
Camphor, . . . aa 3 j,  
Morph. sulphat. . . 3 ss,  
Chloroform, . . . 3 j. M.

Sig. To be applied with a brush to the area to be incised.

**ONTARIO MEDICAL COUNCIL ELECTIONS.**—We publish in another column the address of Dr. Allison to the electors of King's and Queen's territorial Division. So far there does not appear to be any opposition to the worthy doctor's candidature, and we hope to see him elected by acclamation.

Dr. A. S. Fraser, of Sarnia, has been appointed Returning Officer for the Western and St. Clair Territorial Division, *vice* Dr. Richardson, of Chatham deceased.

**A CONJOINT SUMMER SESSION.**—A summer course of lectures, clinical and practical, will be given by the acting staff of the Toronto General Hospital connected with the two medical schools. The session will commence on the 1st of May, and continue ten weeks. The lectures will be delivered in the theatre of the hospital. See announcement in another column.

**CASE OF TRIPLETS.**—Dr. Phelan, of Kingston, reports a case of confinement in which a woman

gave birth to three healthy living children, two girls and a boy—all living. She was 12 hours in labor before the first birth; 25 minutes later, the second child was born; and 35 minutes later, the third was born. Each child had a distinct placenta.

**APPOINTMENTS.**—Dr. A. C. Panton, (Trinity) has been appointed to the chair of materia medica, and Dr. K. A. J. McKenzie, (McGill), to the chair of clinical surgery in the Medical College of Portland, Oregon. Dr. A. Robillard has been appointed a commissioner under the Liquor License Act.

**Hon.** Dr. Parker, of Halifax, Dr. Page, of Truro, and Dr. McGillvary, of Sydney, have been appointed members of the Nova Scotia Medical Board.

**CORONER.**—Dr. C. Sinclair, of Aylmer, has been appointed coroner for the Co. of Elgin, and Dr. A. C. Bowerman for the Co. of Prince Edward, Ont.

**INDEX MEDICUS.**—We are pleased to notice that this valuable monthly publication is to be revived. It will be published by Mr. Geo S. Davis of Detroit. The editors are Drs. Billings and Fletcher of Washington.

**THE** death of Prof. Frerichs, of Berlin, in announced in our Foreign exchanges. He was a man of great ability and his death is a serious loss to German medicine. The death of Dr. Ellerslie Wallace, of Philadelphia, is also noticed in our exchanges.

## Notes, Queries and Replies.

### BRITISH QUALIFICATIONS.

To the Editor of the "CANADA LANCET."

**SIR,**—In reply to Queror in last number of the "LANCET;" I wish to say that I spent one month in the London hospitals, obtaining great insight into special and general diseases. There are some forty hospitals in the Metropolis, but the material is not presented to the best advantage *i. e.* for a graduate to learn much in a short time—more especially in the special sub-divisions of the science.

I attended the Edinburgh New Royal Infirmary for four months devoting four hours per diem to practical work, one hour to grinds and the remainder of the day to study, etc. I succeeded in passing the first conjoint examination of the R. C. P. & S., Ed., and the Faculty of P. & S. of

Glasgow. I may say the feeling of equality extended to a Canadian confrere, materially assisted my chances of gaining practical knowledge. I believe Glasgow also to be a good place to obtain practical instruction, as students are requested to familiarize themselves with the ward work.

I next took Cook's tickets from Scotland to Hamburg, Berlin, Vienna, Paris, London and intermediate points, costing \$75.00, with \$2.00 per day for hotel coupons, and extras additional while on the road. The expenses, when a permanent stay is made in any one place, can be made to suit circumstances. Much was seen that I never expected to see here, and my experience and confidence was advanced many years. Expenses on the ocean can be arranged to suit individual taste. I purchased a first-class return via Allan Line by Quebec and Halifax with R. R. reduced rates for an unlimited season. Expenses in Great Britain I should judge to be about \$5.00 to \$7.00 per week for a long period, with \$130.00 for examinations, \$25.00 for registration, and a few pounds for hospital fees. Extras according to special requirements. For the regulations of the respective corporations write to Dr. James H Albyn Place, Dr. J. Wyllie, R. Infirmary, Mr. Bell, F.R.C.S., Edinburgh, the secretaries of the triple, physician and surgeon qualifications.

The conjoint examination is written, clinical, and oral and lasts a week or more. The subjects are: Medicine (including Therapeutics, Medical Anatomy and Pathology), Clinical Medicine and Surgery, Surgery (including Surgical Anatomy, Operative Surgery and Surgical Pathology), Midwifery (including Gynecology), Medical Jurisprudence and Hygiene. The ward examinations include both medical and surgical cases, besides testing urine and recognizing urinary crystals, etc., bandaging and the use of surgical instruments.

A Canadian must produce his diplomas and other certificates which they demand. The advantages received from the practical work should be the primary and the examinations the secondary object to take one's time and attention. In case of failure at the examination one has the privilege of trying again in three or six months after paying \$25.00 entrance fee which many are obliged to do.

W. F. FREEMAN.

WALKERTON, Ont.

## USE OF PICROTOXINE.

To the Editor of the "Canada Lancet."

SIR,—Would some of your readers give their experience in the use of PicROTOXINE in the sweating of phthisis, and also in what liquid it is best dissolved.

THERAPEUTIC.

New Brunswick, Mar., 85.

**Books and Pamphlets.**

THE LAW AND MEDICAL MEN, by R. V. Rogers, Jr. of Osgoode Hall Toronto, Barrister-at-Law. Toronto: Carswell and Co.,

This little work consisting of about 200 pages, fills a gap in the library of both the physician and lawyer. It deals with the laws relating to the practice of medicine, fees, (who should pay the same), civil and criminal malpractice, privileged communications, expert testimony, defamation, relations with patients, dissection, resurrection, etc., etc. In discussing the subject of malpractice he cites the following, page 61, (J. Woodward in *McCandless v. McWha* 22 Pa Rep. 261) "A patient is entitled to the benefit of the increased knowledge of the day. The physician or surgeon who assumes the healing art is bound to be up to the improvements of the day. The standard of ordinary skill is on the advance, and he who would not be found wanting must apply himself with all diligence to the most accredited sources of knowledge." Where would the fossilized members of the profession who never read a medical journal or any new work on medicine be found in the face of the above ruling?

The book is a very interesting and readable one and should find a place in every physician's library; in view of the fund of information it contains. The statements of law contained in the book are in nearly every instance the rulings of the judges in the particular cases, with citations. We would suggest to the author the propriety of printing the code of medical ethics, as an appendix, in the next edition.

THERAPEUTICS OF THE RESPIRATORY PASSAGES.—By Prosser James M.D. London.

This is one of the best of the monthly issues of "Wood's Library of Standard Medical Works." Every valuable medicament employed in the treatment of the affection of the respiratory passages is

subjected to impartial consideration. The chapters on alcohol, denutrients, and antipyretics are peculiarly instructive, clearly indicating that the author whilst free from the sentimental prejudices of the extremists, is yet gifted with that spirit of candour which should ever be the dominating influence in medical science. The book cannot be read by any practitioner without great profit.

DISEASES OF THE URINARY AND THE MALE SEXUAL ORGANS.—By W. T. Belfield, Chicago. W. Wood and Co: New York.

Dr. Belfield has had the advantage of practically studying the above diseases in a prolific region, and his book presents abundant proofs of his careful observation. In a large city like Chicago, teeming with a very fast population, with strong propensities to illicit pleasures, and exempt from abhorrence of facile divorce, the diseases treated of by Dr. B must constitute no trivial part of daily routine, and and if they are sedulously cultivated, the pecuniary results must be very enticing.

DOCTRINES OF THE CIRCULATION, by J. C. Dalton, M.D., Emeritus Prof. of Physiology, College of Physicians and Surgeons, New York. Philadelphia: Lea Brothers & Co. Toronto: Williamson & Co.

This is a most interesting and well written handbook of the doctrines of the Circulation from Aristotle, Praxagoras, School of Alexandria, Galen, Period of Renaissance, to the dawn of light on this subject, following the discoveries of the Professors of the Universities of Padua, Pisa, Bologna, and Rome. The author also gives the subsequent opinions of Servetus, of the transfer of the blood from the right side of the heart to the left, taking place in the lungs, and not through the septum of the ventricles; also the discovery of the valves in the veins by Fabricius ab Aquapendente, their form, and speculations on their use. He next refers to the doubts of Harvey regarding the correctness of these theories, and his subsequent discovery of the peripheral circulation from the arteries to the veins, and of the return circulation of the blood through the veins to the heart. Space will not permit further notice of the scope of this work, which is of great research, and one that we welcome as a valuable addition to medical literature.

**Births, Marriages and Deaths.**

On the 2nd ult., J. B. Howell, M.D., of Thornbury, aged 34 years.

On February 9th 1885, wife of Dr. A. McTavish, Staffa, Ont., aged 39 yrs.

# THE CANADA LANCET

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## Original Communications.

### OVARIOTOMY.

BY DR. A. M'DONALD, EDINBURGH.

Read before the Obstetrical Society of Edinburgh.

**CASE I.**—M. P., aged 23, unmarried, was admitted in January 24, 1884, complaining of a large swelling in the abdomen, of pain in the right side, of sickness, and of only being able to digest milk diet. Two years ago she suffered severe pain in right side and inability to eat. In August last she first noticed the swelling, and since that time it has rapidly increased in size. She had considerable menorrhagia and metrorrhagia from May till August last year.

*Condition on admission.*—Abdomen extended to size of eight or nine month's pregnancy by a tumor of slightly uneven outline, but, on the whole, of smooth contour. Tumor projects very far forward inferiorly, and seems to be more to the right than left side. Percussion note is dull over anterior surface of tumor, clear in flanks from back. Tumor appears to move slightly under anterior wall with forced inspiration. Measurement round umbilicus  $35\frac{1}{4}$  inches; about  $1\frac{1}{2}$  inches below umbilicus measurement is 38 inches. From right anterior superior spine to umbilicus,  $9\frac{1}{4}$  inches. From left anterior superior spine to umbilicus  $8\frac{3}{4}$  inches. From symphysis pubis to umbilicus,  $8\frac{1}{4}$  inches. *Per vaginam.* Tumor presses down into anterior half of pelvis, displacing uterus to the left and backwards. Uterus appears movable at brim. No part of tumor is found in the pouch of Douglas. Sound enters towards the left and upwards, nearly 3 inches. *Per rectum.* Small body of uterus is distinctly felt apparently separate from the body of the tumor. On February 6th the patient was, after due preparation, submitted to operation. The room had been sprayed for some hours, and the usual antiseptic precautions were

employed, except the use of the spray during the operation. The abdomen was opened with ease. It was then found that the tumor was attached to the right broad ligament, and that there were considerable adhesions of its upper anterior part with the great omentum. Otherwise the tumor was free; the only considerable cyst in the tumor was tapped and about a pint of fluid run off. The edges of the tumor were now surrounded with sponges, and the tumor incised. The hand was then passed into the interior, the multitude of small cysts forming its mass were then broken up, and the contents squeezed out. In this way the tumor was lessened in bulk so as to pass through the abdominal wound, which originally measured about  $3\frac{1}{2}$  inches. The omental adhesions were now fully exposed, and the attached part of the omentum was divided into a number of separate portions and tied by catgut ligatures. The pedicle was very broad and rather thin and short. It was transfixed and tied with silk ligature by the Staffordshire knot. As it seemed to ooze a little after being tied and the tumor separated from it, the loose ends of the thread were brought round the base of the pedicle and again tied. The sponges were now removed from the abdomen and the whole cavity thoroughly sponged out. The omentum was carefully inspected and no bleeding point discovered. The ligature was now cut short and the pedicle dropped. The abdominal wound was secured by deep and superficial sutures and the wound dressed with protective and salicylic wool and a flannel bandage. The patient was put to bed, surrounded by hot bottles, and a brandy enema administered. The operation lasted  $1\frac{1}{4}$  hours. The solid weight of the tumor was 4 lbs. and the fluid above 12 lbs. The patient's recovery was excellent, though somewhat attended by persistent sickness and vomiting, which lasted for the first ten days after the operation, during which time she was fed by enemata. In the first few days the temperature ranged from 100 F. to 101.8, after that it became normal and remained so. Deep stitches removed on the seventh day, union complete. Patient improved daily after vomiting ceased, and was dismissed on March 10th, 1884, perfectly well.

*Remarks.*—Since the patient returned home I have heard that she continues to keep well. It is to be noted that the way the tumor was fixed

above by the omentum, and below by the pedicle, rendered its removal a little difficult. The fact, also, that its mass being made up of small cysts with thick contents did not permit of its bulk being materially lessened by tapping, I was obliged to incise it and break up its contents. Some anxiety was caused by finding that the fluid contents of some of the cysts, when subjected to microscopic examination by Dr. Foulis, were found to contain sarcomatous elements. This led to a special examination of the tumor, and the detection of sarcomatous thickening of certain portions of its walls. But, as there were no proliferating masses on any part of the surface of the tumor, we have the best reason to expect that the patient will do well, having escaped infection from the sarcoma.

CASE II.—M. P., æt. 21, no children, admitted December 18, 1883, complaining of pain in the right groin. Twelve months ago patient was suddenly seized one evening with a sharp pain in her right side; mustard was applied and relief was obtained for the time. From that time till now patient experienced at times a feeling of heat in the side. Menstruation natural. Health always good.

*Condition on admission.*—General appearance flabby and chlorotic. Abdomen distended to about the size of a seventh month pregnancy. The tumor is more developed towards the left than the right. Measurement round the most prominent part of tumor, about an inch below umbilicus, is  $30\frac{1}{4}$  inches. From umbilicus to right anterior superior spine,  $6\frac{1}{4}$  inches; to left anterior superior spine,  $6\frac{1}{2}$  inches. Tumor feels smooth all over, appears to move with respiration. Percussion in right flanks clear, on left somewhat dull. Anteriorly over whole tumor is marked dullness. Fluctuation and fluid thrill are felt throughout the tumor. *Per vaginam.* Posterior part of pelvis and entire inlet are blocked by a tumor which moves in unison with abdominal tumor to a certain extent. The uterus is displaced to the left and upwards. Cervix uteri can be reached, but with some difficulty. Sound passes up and forwards without pain  $2\frac{1}{4}$  inches.

Dr. Macdonald performed ovariectomy on Dec. 26, 1883. On entering the peritoneal cavity the omentum and a portion of the bowel were found adherent to a large cyst, which occupied the right

side of the abdomen. On the left side the same cyst was bare, the aspirator was passed, and about 90 oz. of a dark amber colored fluid drawn off. On attempting to remove the cyst it was found to pass deep down into the very base of the pelvis, so that it was impossible to complete the removal without 1. separating the bowel adhesion: 2. opening the broad ligament so as to get the cyst gradually enucleated from between its folds. In doing so some hemorrhage occurred, necessitating very numerous ligatures. The tumor, towards the uterine end, was firmly adherent to the broad ligament, so that the latter had to be partly included in the pedicle and partly torn into small pieces and tied. The pedicle proper was very thick and hard and short, and proceeded from the right upper angle of the uterus. On examining for the left ovary there was found protruding from the left broad ligament, in the site of the normal ovary, an elongate bowel-like cyst, with exceedingly thin walls, which occupied the left iliac and left lumbar regions. Over its anterior surface, and firmly adherent thereto, passed a considerable knuckle of intestine. As far as could be judged, the cyst bulged between the layers of the meso-colon. The bowel was firmly adherent to this cyst down to its pedicle proper, which proceeded from the left upper corner of the uterus in the same manner as the other cyst from the right. There was considerable difficulty and much bleeding during the separation of the bowel from this cyst, numerous ligatures being used. During process of separation of cyst it burst, and a large quantity of clear serous-looking fluid was squeezed out. Pedicle was now secured close to uterus, and its other adhesions tied in portions and divided. There was seen to be still some oozing from right side and floor of the pelvis, but no distinct bleeding points could be described. Abdominal wound was brought together in the usual fashion after the cavity had been well sponged out, wound dressed, a glass drainage-tube having been introduced into its lower angle. Patient put to bed with hot bottles, and a brandy enema given. The patient was much exhausted after the operation, and a second enema was given. On day of operation at 5 p.m. pulse was feeble, 130 per min. Dressing changed. There was squeezed from sponge and sucked from glass tube 5 oz. of sero-sanguineous fluid. An ounce of brandy ordered every 2 hours. 10 p.m.,

pulse stronger; temperature, 100.2. {Dec. 27<sup>th</sup> 10 a.m.: Wound looks healthy; 9 drachms sero-sanguineous fluid sucked from tube. Pulse firmer, ordered to diminish brandy by one-half. 5 p.m., Dressing changed; 8 drachms sucked from the tube. Temp. 100, pulse 139. One-ninth grain of morphia and  $\frac{7}{8}$  gr. atropine given hypodermically. Dec. 28, 10 a.m.: Patient seems easier. 1 oz. sanguineous fluid got from tube and sponge. Temp. 99.2, pulse 128. 2 p.m.: Temp. 100.4, pulse 140. Dec. 29: Hypodermic of morphia and atropine given at 1.30 a.m. and 10.30 a.m. At latter hour discharge was septic and offensive. Dr. Macdonald washed out abdominal cavity with warm carbolic lotion 1-100. 3 p.m.: Temp. 100.8, pulse 150; another hypodermic given. 10 p.m.: Abdomen again washed out. 12 p.m.: Temp. 102.4. Dec. 30: Temp. gradually rose to 103, then 104 at 6.50, when patient died. No post mortem allowed.

*Observations.*—This case presents points of special and unexpected difficulty. Considering that there was no free fluctuation in the tumor and that the patient was a healthy woman, there appeared no ground to expect unusual operative difficulty, except in the fact mentioned in the case that the tumor projected deeply down on the right side of the uterus. It would almost appear that in this case we had to deal with two huge enlargements of the Fallopian tubes. At any rate, from the peculiar shape of the tumor on the left side, there is the best reason to regard this as most probably of tubal origin. The parts comprising the broad ligament were so disfigured by pressure of the cysts that it was impossible even with the most careful scrutiny, to detect any trace of ovaries or tubes to make certain that the cyst originated in the tubes. But the close connection of each pedicle the tumors possessed with the upper angle of the uterus seems to imply an origin from the tubes. I cannot help thinking that, notwithstanding the severity of the case, all might have gone well had she not had in the large wound some rather putrid pus. The drainage-tube seems to have been a source through which the putrid fluids were made septic. I need hardly say that we used every precaution in our power by protecting the end of the tube from the air to avoid this result. Be this as it may, it is evident that the patient died of septicæmia in spite of all efforts.

## POLYPOID FIBROMA OF THE BLADDER.

BY J. FULTON, M.D., M.R.C.S., ENG., L.R.C.P., LON.

Prof. of Surgery Trinity Medical College, Toronto;  
Surgeon to Toronto General Hospital, etc.

Primary neoplasms of the bladder are exceedingly rare, and when they occur attract no small degree of interest from a surgical point of view. Sir Henry Thompson in his work on the Urinary Organs (second edition) says: "Tumors proper to the bladder are of rare occurrence. Simple fibrous growths, chiefly in the form of polypi springing from the walls of the bladder and wholly unassociated with the prostate, are the rarest of all forms, known to me personally only in museums. Prof. Gross, of Philadelphia, in his admirable work on "The Urinary Organs" also states that polypoid fibroma is exceedingly uncommon, "excluding the cases recorded by Lusitanus, Kirchner, Sylvius, Rollin and other older authors, and those in which villous hypertrophy is a prominent feature of the growth, fifteen cases of fibrous polyp have been collected, of which eight occurred in males and seven in females, their ages varying from thirteen months to 56 years. In only six were the subjects impubic, the average age being the 20th year. The duration of the disease ranged from five weeks to three years, the average being fourteen weeks. Dr. Stein, of New York, in an excellent monograph on this subject states on the other hand, that polypi are more common in early life than any other kind of tumor. The subject of the present history was a male child aged one year and eight months, the youngest of a family of eleven; eight living and three dead. One died of inflammation of the bowels, another of croup, both under one year, and the third a little girl of five years of age was accidentally killed. The parents were perfectly healthy, and this child was healthy at birth, but at the age of three months he had some eruption of the scalp which the doctor called "scald head." This was soon relieved by treatment, after which he seemed perfectly healthy until some months afterwards when he appeared to be suffering from internal pain and swelling of the scrotum. The parents consulted the ordinary medical attendant, who thought the child was ruptured, and recommended them to obtain the advice of a neighbouring practitioner. Upon examination he diagnosed hydrocele and removed the fluid. This was about two weeks after the child first began to complain.



At this date there was no suspicion of anything being wrong with the bladder. The little patient seemed better for a short time after the removal of the fluid, but soon began to complain as before, especially when he attempted to urinate. The effort at micturition was attended with a good deal of straining and bearing down pain, and the child was constantly pulling at the prepuce. The parents again took the patient to the consulting surgeon and gave him an account of the symptoms. He immediately suspected stone of the bladder. He did not sound him at the time, however, as he had no suitable instrument, but told them to call back in a week or ten days. It was about two weeks before they returned, the symptoms evidently not being very urgent at that time. The surgeon administered chloroform, introduced the sound and examined carefully. He could detect no stone, but felt some thickening of the anterior wall of the bladder. Considerable hemorrhage followed the introduction of the sound. The child continued to strain very much in urinating, and now and again seemed threatened with retention of urine. A few days after the introduction of the sound, there was again some hemorrhage from the bladder; these were the only occurrences of hemorrhage. The amount of blood was not great—probably about half a teacupfull. The surgeon in charge then advised the parents to take the child to the Toronto General Hospital for treatment, and he was admitted under my care. At the time of his admission his mother stated that he had not passed any urine for nearly 24 hours. The abdomen was enlarged and felt quite hard as if the bladder was ready to burst. I introduced a catheter, but was astonished to find that only a small quantity of urine mixed with muco-pus escaped. On placing my hand over the abdomen it still felt quite hard, and there appeared to be a solid mass between the point of the catheter in the bladder and my hand, for which I could not account. On examination per rectum, I made certain that the instrument was in the bladder, and the posterior wall of that viscus felt quite normal. On the supposition that it might be an abscess in the abdominal wall, I ordered the child to be put to bed, to have a warm poultice applied, and a few drops of laudanum administered. This gave great relief. As might have been expected there was considerable febrile disturbance; skin hot and dry. The

bowels were kept freely open. On the following day the catheter had again to be introduced as the child was still unable to pass any urine. After drawing off the urine, which was small in quantity and mixed with pus, I introduced a very soft catheter with the view of leaving it in, but it was not long until the child, in one of its fits of straining which came on at intervals of a few minutes, forced it out with great violence. I then introduced a small silver catheter with a short beak and tied it in. Through this the urine escaped for the next two or three days. In the meantime there was no amelioration of the symptoms—the child was evidently growing rapidly worse. I had held out no hopes of the child's recovery to the mother from the first. Fearing that the catheter might increase the irritation I removed it, and drew off the urine as required by means of a gum-elastic catheter. Although somewhat puzzled at first in regard to the diagnosis, I had now come to the conclusion from a close scrutiny of the history, that it was a case of polypoid fibroma of the bladder. I stated my conclusions to several of my confrères, but they seemed incredulous. Some thought it was a perineal abscess, and advised me to make an incision. This opinion was, in some measure, justified by the fact that the urethra was enlarged, and pus from the bladder escaped through it during the last day or two of the child's illness, but as I had watched the case closely and examined the parts carefully, I felt certain there was no abscess. The passage of a small polypus about this time verified my diagnosis. The child died on the 11th day from the date of admission, and a *post mortem* examination revealed the true nature of the case. The bladder was completely filled to distension with polypoid growths which sprang from a pedicle about an inch in width and a quarter of an inch in thickness, and was attached to the left anterior wall of the bladder. The coats of the bladder were thickened except at the summit, which had ultimately given way by ulceration. Urine and pus escaped into the abdominal cavity and brought on fatal collapse. The ureters and pelves of the kidneys were very much dilated, and the kidneys more or less congested. The urethra and neck of the bladder were also dilated. The polypoid growths which were globular in shape, smooth and even, have shrunken very much since placing the specimen in alcohol. Under the microscope the tissue appears lax and

succulent, and made up of delicate interlacing filamentous tissue. It is not very vascular, and is covered with a reflection of the mucous membrane, the cells of which are normal. Prof. Gross tells us in his admirable work above referred to that "these tumors occasionally co-exist with urinary calculus, or they may be encrusted with crystals of triple phosphates, and that they evince a remarkable predilection for the neck of the bladder."

The symptoms of polypoid fibroma are chiefly of a mechanical character, viz.: difficulty in micturition, sudden stoppage of the flow, painful retention accompanied with great straining, requiring the frequent use of the catheter. The occasional passage of a small polypus as in the present instance, will at once establish the diagnosis. There is usually very slight hemorrhage, which may only be occasioned by the introduction of instruments. There is frequently pain at the head of the penis as in stone of the bladder. In females a protrusion of the tumor from the urethra is a valuable symptom. In this connection a most interesting case was published by Mr. Stanley in the *Medical Times and Gazette* of 1852 (page 106) in which, from continued retention of urine, some of it was forced into the imperfectly closed urachus which gradually reopened until the urine reached the umbilicus and escaped. The patient was a male child 13 months old.

The differential diagnosis of polypoid fibroma may be made by having regard to the train of symptoms just stated. It occurs at an earlier age than papillary fibroma, and unlike it, bleeding is not a frequent sign, and when it does occur is only trifling in extent. It may be diagnosed from carcinoma of the bladder, from the fact that the latter is rarely primary, and is attended with the cancerous cachexia—from calculus of the bladder by the introduction of the sound. From hypertrophy of the prostate by the introduction of the finger in the rectum. The prognosis of this affection is most unfavorable as when it is not removed by surgical procedure, a fatal issue invariably occurs from retention of urine and its effects upon the kidneys.

The treatment of tumors of the bladder is palliative and radical. The former consists in administering remedies to allay pain and spasm, the use of the catheter when required and the arrest of hemorrhage when it occurs. Among the earlier operators in these affections was Civiale. He en-

deavoured to remove them by avulsion and the use of the lithotrite; but his success was not very encouraging. Cystotomy is the only rational method of treating these growths. They may be removed by avulsion, enucleation, ecraseur, or ligation. The fact that the operation has been several times successfully performed should encourage us in its performance whenever suitable cases present themselves. Billroth, after having first verified his diagnosis by opening the bladder through the perineum, divided the recti muscles at their insertion, opened the bladder transversely, and removed the tumor by avulsion. The patient was discharged cured on the 23rd day. Dr. Mass, of Breslau, in 1876, suggested a plan which it would be well to have recourse to before subjecting the patient to a cutting operation. It consisted in pouring water into a double current catheter (with a large eye) inserted in the bladder, in the hope that the out-flow may entangle the growth in the eye of the instrument. In this way he succeeded in three cases in removing small pedunculated mucous polypi. The lithotrite might also be used to remove portions of the growth for examination. In females the short and easily dilated urethra and absence of the prostate renders access to the tumour tolerably easy of accomplishment and the risk is much less; not unfrequently also the tumor protrudes through the urethra and may be ligated or pulled well down and removed by avulsion. In the case before us, from the nature of the growth and its attachment, an operation would, in all probability, have been attended with success if the diagnosis had been made with certainty sufficiently early, *i. e.*, before the disease had progressed to the stage of ulceration of the bladder. In any similar case occurring under my care in future I should have no hesitation in performing cystotomy with a view to the removal of the growth. The operation has met with a large measure of success in the hands of Sir Henry Thompson and others.

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#### SURGERY OF THE SPINAL CORD.\*

BY J. CAMPBELL, M.D., L.R.C.P. ED., SEAFORTH, ONT.

The very interesting and important subject of what now generally goes by the name of "Railway Spine," has, during the last year, been attracting

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\*Report on Surgery Ont. Med. Association, 1884.

renewed interest. This has been owing in a great measure to the publication of Page's work "On the Injuries of the Spine and Spinal Cord." Mr. Page has been for a number of years surgeon to one of the greatest railway corporations in England, and, therefore, had a very extended experience of all possible railway injuries, and particularly of cases of so-called "Railway Spine." He contends that cases of what are commonly called "concussion of the spine," do not exist, except in the imagination of the surgeon making the diagnosis. By concussion he means the cord receiving an injury of such a nature as to give rise to pronounced symptoms, without, at the same time, the vertebræ, ligaments or membranes receiving any hurt.

It is well-known that Mr. Erichsen has been a strenuous advocate of the theory that the great majority of cases of railway injuries having for their symptoms, spinal symptoms, are due to concussion of the spinal cord. The first one hundred pages of Mr. Page's book are taken up with combating this view of Erichsen, and it appears to me that Mr. Page's attempt has been successful. He, at least, conclusively shows that the vast majority of cases of concussion of the spine are nothing more nor less than cases where the lumbar muscles or ligaments of the spine have been sprained or ruptured. Erichsen contends that many cases of "concussion of the spine" received in railway accidents never recover, while Page, on the other hand, maintains that these so-called cases of spinal concussion always do recover. While representing the reaction, Mr. Page's recent work certainly favors an undue belief in the certainty of recovery in cases of this sort.

Erb presents the matter more fairly than either of these writers. Accidents which occur in railway collisions, as other accidents, may lead to a long train of nervous symptoms, and when death has resulted, a post mortem examination may show little apparent cause for the fatal result. In the greater number of these cases the pathology is a riddle, which, for its satisfactory solution, will need a great deal of experiment and careful and extensive post mortem investigation. The great trouble in coming to an opinion as to the nature and cause of a train of nervous symptoms following a railway injury is not whether we have to do with a functional or organic change, but whether we have to do with an actual or feigned train of

symptoms. Usually the patient's symptoms are of such a nature that the physician can come to a conclusion without much trouble, but where he has to do with an intelligent and unscrupulous man who expects a large sum from a railway company, the case is one of extreme difficulty. In many of these cases it is quite impossible to come to a certain diagnosis.

In the words of a recent writer, the "needed clinical work, it seems to us, in the study of 'railway spine' is the determination of clearly defined types of the disease, and the investigations of the variations from this type, and the certain relation of objective symptoms to the disease." That serious and even fatal effects may arise from changes in the cord where it has not received any direct injury has been abundantly proved. In the current number of one of our periodicals there is a very instructive case reported, by Dr. Edmunds, of a soldier who was struck in the back with a bullet. He fell immediately, and had to be carried out of action. The bullet entered the back two or three inches from the spine, and the surgeon who first attended him considered that the spine was severely injured, because the patient had lost complete control over both lower extremities. Patient had paralysis of the bladder and rectum also. There was cystitis and a bed sore over the sacrum before death, which occurred five months after the injury. At the autopsy there was no fracture or indication of fracture, or dislocation of the vertebræ to be found. The cord was seen to be much atrophied and softened about the level of the wound. On hardening the cord in Müller's fluid, it was seen that there was universal myelitis and softening for about two inches opposite the wound, this gradually passing below into sclerosis of the lateral and anterior pyramidal tracts, and above into sclerosis of the posterior columns. There was no indication of hemorrhage, either external or into the substance of the cord. Its surface was uninjured. This was undoubtedly a case of pure "spinal concussion." The immediate paraplegia following the injury could not have been due to any other cause. The case is then one of very great importance, as it proves most conclusively that we can have from a severe shock sufficient changes brought about in the spinal cord to cause death, and that these changes were in the first place nothing more or less than "concussion of the spine."

Very recently the opinion appears to be gaining ground that we may have *tabes dorsalis* arise from peripheral causes. That, in fact, an ulcer in the foot may be the *fons et origo mali* of this formidable disease. The origin of the disease in such cases is explained by first a peripheral neuritis gradually extending along the course of the nerves until it reaches the posterior roots, and there a similar process gives rise to a subsequent sclerosis of the posterior columns.

## SURGICAL DISEASES OF JOINTS.

BY H. P. YEOMANS, M.D., MT. FOREST.

Report on Surgery, Ont. Med. Association.

In cases of very great distension with continued pain in the later stages of acute or subacute synovitis, Barwell recommends puncture and withdrawal of the fluid. This is accomplished with a sharp small tubular needle, having a rubber tube attached. Pressure is made by an elastic bandage around the knee so as to press out the fluid and prevent the entrance of air. The rubber tube may be filled with a solution of carbolic acid and held above the joint until the puncture is made. After the needle has entered the cavity containing the fluid, the tube may be lowered and its free open end placed in a carbolic solution. By this means tension is relieved, and consequently pain; means must afterwards be adopted to lessen inflammation such as cold, or in some cases heat, etc.

Suppurative synovitis may, after evacuation, be treated by complete rest and thorough drainage. The temperature falls or rises as the pus is retained or thoroughly washed out.

In hip-joint disease rectal examination has been employed in addition to other methods of diagnosis. The symptoms discovered by a rectal examination are pain on pressure upon the os-innominatum behind the acetabulum—enlargement of the intra-pelvic glands, thickening of the bones, depression, flexibility, mobility, or destruction of the post-cotyloidean surface, congestion of the soft parts pelvic abscess—one or other of these symptoms may be found in different stages of the disease.

With regard to treatment, Dr. Hutchinson deprecates the application of any retentive apparatus whatever. The patient wears a high heeled shoe on the sound limb, is provided with a pair of crutches and allowed to go about. He points out

"that immobility is secured by reflex contraction of the peri-articular muscles, aided by intracapsular effusion and the voluntary effort to keep the joint at rest on account of the pain which motion produces."

Splints of all kinds allow more or less mobility of the joint and interfere with freedom of the patient in moving about in order to obtain necessary exercise. There appears to be considerable difference of opinion as to the efficiency of all the various appliances and methods of treatment.

## Reports of Societies.

MICHIGAN STATE BOARD OF HEALTH.

(Reported for THE CANADA LANCET.)

The annual meeting of the Michigan State Board of Health was held in Lansing, Mich., April 14, 1885. All the members were present. The president's address was the first order of business. He congratulated the Board on what it had achieved. He thought it would be well to continue holding sanitary conventions in different places in the State. He spoke of the probable advent of Asiatic cholera, and thought that it might tax the Board to its utmost. The Board had done all it could to prepare to resist the disease, but should be ready for further action. If the bill before the legislature becomes law, the powers of the Board will be increased. He advised police regulations in cities, to prevent unsanitary conditions; and said that health officers of cities, villages and townships, especially those recently appointed to that office, should be instructed in regard to their duties.

The Secretary read a report of the work of the office during the past quarter. Ten thousand copies of the document on the restriction and prevention of contagious diseases were distributed. The Secretary also stated that the outbreak of smallpox at South Boardman had been suppressed.

At the last meeting of the Board, the subject of proposed legislation relative to diseased animals, and also relative to a standard for milk, had been referred to a committee, and bills relating to those subjects had been introduced into the House of Representatives.

The Secretary reported that there had been considerable effort to get the legislature to lower the

standard test for dangerous oils, and to do away with the use of the tester adopted and recommended by this Board. It was claimed that the changes were needed in the interests of small manufacturers. The proposed change would lower the standard about ten degrees. A resolution was passed deprecating the lowering of the test now required for illuminating oils.

The Secretary read the report by Surgeon Geo. M. Sternberg, U.S.A., now at John Hopkins University, on his experiments on lower animals in feeding, and in making injections of culture-fluids of poisonous cheese, with the view of learning the nature and source of the poison.

Dr. Vaughan gave a report of his experiments with poisonous cheese. He had secured in a crystalline form a substance from poisonous cheese which would produce in man symptoms common to cheese poisoning. There might be other poisons in poisonous cheese. He had not yet fully studied the poison he had obtained. It gave reactions like those of a ptomaine.

The Board recommended a sanitary survey of the cities and villages in the State, and the adoption of such measures as may be necessary to place them in a good sanitary condition.

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### Selected Articles.

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#### FORTY YEARS' EXPERIENCE IN MIDWIFERY.\*

BY W. SYMINGTON BROWN, M.D., OF STONEHAM, MASS.

The art of midwifery belongs to prehistoric times; the science of obstetrics is the latest recognized of all the ancient sciences. There is no branch of medicine which demands more skill, presence of mind, or justifiable daring than midwifery. It needs a man who can neither be overwhelmed by disaster nor unduly elated by success,—one who has the courage and honesty to do whatever is best for his patient, irrespective of consequences. Of such men no profession possesses a superfluity.

It is a strange fact, however, that only sixty years ago practitioners in midwifery were not admitted as Fellows to the College of Physicians, London, on the ground of inferiority, and the Royal College of Surgeons did not require candidates for its diploma to undergo an examination in obstetrics. This odium has nearly disappeared in our day, but

a single item illustrative of its vestiges may be cited. I refer to the fact that the popular encyclopædias of our own day make no reference to the lives of prominent obstetricians, such as Smellie, Levret, or Naegele. Hundreds of insignificant names are recorded in Appleton's, Chamber's and Johnson's Encyclopædias, but a profound genius like William Smellie—writer, teacher, inventor and artist—is not even mentioned.

During a short visit to Scotland, in 1878, I met a lady, thirty-five years old, at whose birth I officiated obstetrically. And I had attended more than a hundred midwifery cases before that one. I wish I possessed a record of them all. While a medical student I served three years as assistant to the late Dr. James Paterson, Professor of Midwifery in the Andersonian University, and delivered many women among the destitute poor of Glasgow. During the last nineteen years I have kept a moderately full record. The whole number, dating from 1840, must exceed 2,000 cases.

In 1842 forceps were rarely used. It was a period of reaction, and many physicians entertained a strong prejudice against their employment, except in extreme cases. Dr. F. H. Ramsbotham, physician to the Royal Maternity Charity, London, in summing up the symptoms warranting recourse to forceps says: "If the pains have entirely disappeared, if the strength is failing, the spirits sinking, the countenance becoming anxious, if the pulse be 120 or 140 in the minute, the tongue dry, brown, and raspy; if there have been two or three rigors; if there be green discharge; if the head have been locked for four hours, and made no progress for six or eight hours; if the patient be vomiting a dark, coffee-ground-like matter; if there be hurried breathing, delirium, or coldness of the extremities." *then* we may use the forceps—before sending for the undertaker.

I recollect attending one case in Glasgow during a long-drawn-out week. The woman was very poor, and had been compelled during the whole period of gestation to sit from fifteen to eighteen hours a day, winding pirns, in order to earn a bare subsistence. There were no alarming symptoms, but the abdominal muscles seemed to be powerless. I sent for Dr. Paterson, and requested him to help her flagging powers with the forceps, but he declined to do so. The case did not come under any of Ramsbotham's excuses. At last the poor woman got tired of waiting; she sent for a doctor with fewer scruples and was instrumentally delivered. This case made a deep impression on my mind, and, in fact converted me to the faith which I hold to-day.

In this paper I propose to state very briefly the principal conclusions I have arrived at under six heads, namely: Forceps, Turning, Ergot, Anæsthetics, Antiseptics, and Craniotomy. Before doing so, however, allow me to make one remark in regard to

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\* Read before the Obstetrical Section of the Suffolk District Medical Society, January 21, 1885.

the language employed. Although what follows may appear like laying down the law in a somewhat curt fashion, such is not my intention. What follows are simply my own opinions on certain obstetrical problems colored by the personal medium. Nobody is more anxious than I am to be set right where I have been wrong. The late Dr. J. C. Warren, in his classical work on "Tumors," gives us this good advice: "He (the surgeon) must get the opinion of other surgeons. Even those who have not so much experience as himself may afford him excellent hints, and strike out from his own mind thoughts which without this collision would not have been elicited." Dr. Barnes also truly asserts that "there is no man whose experience is so great that nothing is left for him to learn from the experience of others." Such societies as this one answer that purpose.

#### FORCEPS.

I prefer curved to straight forceps. They are about as easily applied, and are less liable to slip. If a beginner can only afford one it should be a long pair, either nickel or silver plated. But it is convenient to own a short pair, and I always carry one in my obstetrical bag, along with a No. 6 gum-elastic catheter (male), a Davidson syringe, a hypodermic syringe, a few feet of flat covered wire (such as milliners use), ether, ergot, chloral and whiskey.

The short forceps may be used at any time when their employment will benefit the patient or her coming child. We should *not* use them merely to save our own time. But the long forceps (when applied within the uterus) should seldom or never be used without a consultation. Indeed, it is a wise precaution, in most difficult or dangerous cases, to call in a brother practitioner to share the responsibility. I make it an invariable rule to pass a soft catheter into the bladder before applying forceps. In some cases using the catheter helps progress, even when forceps are not needed. If the rectum contains solid fæces I also give an enema of warm soapsuds.

How should the forceps be applied? In Scotland the woman is placed on her left side, with her hips projecting from the bed. In this country the dorsal position is preferred, and it is the one I most frequently use. Lately I have tried a new way, which has certain advantages. The woman lies on her back in the centre of the bed or anywhere, and is not moved at all. Of course, it is not convenient to use long forceps in this position; but, when practicable it avoids the appearance of preparing for a surgical operation, and I think the less fuss we make the better it is for our patient.

In most cases I insert each blade at the side of the pelvis, without regard to the position of the child's head. If the vertex presents, you can scarcely go wrong by following this rule, and it

saves the patient the annoyance of searching for an ear and other annoying manipulations. I make traction only during a pain, and relax pressure when the pain abates. I think it is advisable to pull with a slight pendulum motion, instead of using direct traction, on the same principle that it is easier to pull down a pair of tight pantaloons by drawing on alternate sides than by pulling on both sides at once.

#### ERGOT.

As a means of shortening labor, ergot is seldom employed nowadays. The forceps have crowded it out of use for that purpose. But as an agent in promoting uterine contraction, after delivery of the placenta, and especially in cases of threatened flooding (some women have a hæmorrhagic idiosyncrasy), it is a valuable remedy. One reason why ergot has fallen into disrepute is the poor quality of many specimens offered for sale. Dr. Squibb's aqueous extract rarely disappoints me. It should be borne in mind, however, that no drug is readily absorbed during extreme depression.

After much blood has been lost our main reliance should be placed on other agencies, such as injections of very hot water and mechanical pressure. The accoucheur's hand inside the womb, with external counter-pressure, is the most reliable method. In milder cases I have succeeded in arresting severe hæmorrhage by injecting hot water and vinegar into the flaccid uterus. But the water must have a temperature of 130° F. in the basin, as it cools during its passage along the tube.

#### TURNING.

As this operation requires no surgical instrument, it obviously antedates the forceps, and, since the days of Ambrose Paré, has been a favorite with many practitioners, and even with skilled midwives. I was acquainted with a physician who, if one might draw an inference from his usual practice, seemed to think that nature had made a mistake in placing the child upside down in the womb. In our own day the late Sir James Simpson, Dr. Barnes, and Dr. Braxton Hicks have done much to bring version into favorable notice. On one occasion, before labor had fairly commenced, while making an external examination, I detected the child's head above the brim, and succeeded in converting a cross presentation into a normal one by the Braxton-Hicks method. I was agreeably surprised at the ease with which the change was effected. But, notwithstanding the plausible arguments advanced by Simpson, Barnes and others, I have come to the conclusion that turning, after the evacuation of the liquor amnii, is a very dangerous operation for the child, and not much safer for the mother. I admit that cases occur where no other alternative (except Cæsaréan section) is left us. If we conclude to turn, the operator's left hand should be used, and, in most cases, it is better to bring down one foot than

two feet. The accoucheur's left hand is the obstetrical hand *par excellence*. Physicians should learn to use it adroitly more than they do.

#### ANÆSTHETICS.

The foremost question under this head is, Do anæsthetics injure the patient? I am pretty sure that they do not. Since 1849 I have used ether, chloroform, or a mixture of the two with alcohol, in every case where the woman was willing to breathe an anæsthetic. Some object; they are afraid to take it, and these I do not urge; but the majority are glad to get it before the labor is over. As a general rule I do not give ether during the first stage.

High authorities tell us that there is a greater tendency to post-partum hæmorrhage after ether or chloroform has been administered. During the last sixteen years I have not employed chloroform in midwifery practice, except as a remedy for convulsions; but I believe that ether, in moderate doses, does not tend to bring on flooding. Ether is seldom given to the extent of unconsciousness. The patient knows what is going on, and can render voluntary assistance when solicited.

A small dose of ether acts beneficially in two ways: it blunts sensibility to pain and allows the abdominal muscles to aid in propulsion. Without ether the patient's will-power is instinctively exerted to delay the labor; with it the canal is more likely to be relaxed, and the voluntary muscles are not so much restrained. The contractile power of the womb itself is not affected by moderate inhalation of ether.

#### ANTISEPTICS.

Cleanliness is a good thing in midwifery, and antiseptics are its aides-de-camp. A young doctor who keeps his nails in mourning will eventually have to mourn the absence of a lucrative practice. Still it is possible to have too much of a good thing. Dr. Thomas, of New York, has recently taken a stand on this subject which most physicians would call ultra. The rules and regulations he lays down might possibly be enforced in a hospital, but hardly in private practice. And even if they could be carried out, I question the advantages of trying to surround a physiological process with all the paraphernalia needed in a surgical operation. Carbolic acid has had its flood-tide, and begins to ebb. Corrosive sublimate will probably follow suit at no distant day. Please observe, I do not object to disinfectants or antiseptics in themselves. Both of the chemicals mentioned will no doubt, be used occasionally with advantage. But I believe that carbolic acid nearly killed Dr. Thomas Keith, and not a few unfortunate patients have suffered from its wholesale reckless employment. I greatly prefer a weak solution of iodine, prepared with iodide of potassium, which may be diluted with water without precipitation, or a hot

solution of permanganate of potas. In ordinary cases absolute cleanliness is all that is needed. The routine employment of vaginal injections is likely to do more harm than good. I concur in the opinions expressed by Dr. Adams, of Framingham, in his interesting paper read at your last meeting. Dr. William Godell's suggestion that lying-in women should be encouraged to assume the erect posture early, with a view to facilitate the removal of clots and *débris*, is an excellent one.

As already hinted, it is a good plan for the obstetrician to wash his hands, keep his finger nails pared pretty close, and to fill the small remaining space with softened soap before making a vaginal examination. A Syracuse æsthetic M.D. kindly suggests that no harm would result if he also washed his hands afterward.

#### CRANIOTOMY.

During the last nineteen years I have performed craniotomy three times, all of the cases occurring in the practice of other physicians. No operation tries a surgeon's nerve more than this one. When we are sure that the child is dead, of course it is plain sailing. But there are cases when the foetal heart cannot be distinctly heard, and yet the child is alive. To plunge a perforator into a living child's skull, and deliberately take its life, with the view to save that of its mother, is, to say the least, a sad alternative. I hope I shall never feel compelled to do it again. In these days of successful abdominal surgery, would we not be justified in appealing to the patient to allow us to perform the Cæsarean section or laparo-œlytrotomy? But we should not wait till the woman is at death's door before operating. In this, as in all other life-saving operations, promptness and decision win the day.

The medical profession is deeply indebted to Dr. Thomas for his efforts to popularize laparo-œlytrotomy. I understand that he tried the operation several times on the cadaver before performing it on a patient. Nearly all great surgeons have been in the habit of doing this. In this case the principal difficulty will be to get the consent of the patient and her friends in season to be of any service. We all love to put off the evil day, or even the evil hour, and so the golden opportunity slips through our fingers. But as successful results in this line increase the dread of the operation itself will decrease, and obstetric surgery may achieve a new triumph in the salvation of human life.—*Boston Med. & Surg. Journal.*

#### SUGGESTIONS FROM DISPENSARY EXPERIENCE, FOR THE SURGERY OF GENERAL PRACTICE.

BY DR. C. W. DULLES, PHILADELPHIA.

It has often seemed to me that the experience gained in the many dispensaries of our large cities



is not made of as much service to the profession as it might be, and that it would not be amiss if those who have the advantages which these positions afford would occasionally try to put into accessible shape the lessons which they have there learned, and lay them before their brethren for adoption or correction. And, because I have had to learn by experience some things which it would have been better for my patients if I had found out in some other way, I have thought it might be worth while for me to invite your attention to certain notions in regard to the kind of surgery which occurs in general practice, which I have gathered during the past ten years, and which, if they are correct, may be helpful to others; if they are incorrect, I shall be glad to have them criticised.

#### I. THE DIAGNOSIS OF SURGICAL LESIONS.

I trust I shall not be deemed officious in urging the importance of thoroughness and discernment in making up a diagnosis as to what is the nature of the lesion for which one is consulted by a sufferer. Every writer, and every lecturer, dwells, more or less, upon this point. But, in spite of all that is said and written, mistakes are constantly being made, which greater care would have prevented. I have seen fractures treated as contusions, and contusions as fractures, over and over again. I have seen a patient treated for a fracture at the lower end of the radius with a time-honored Bond's splint, who had nothing the matter near the wrist, but who had a severe and dangerous contusion of the elbow-joint. I have seen hydroceles treated for years as herniæ, and have been called to operate for strangulated inguinal hernia when there was only a hydrocele of the cord, innocent and easy to cure. I have seen a psoas abscess mistaken for a hernia, and over and over again sinuses of the face, due to disease of the root of a tooth, treated in vain as simple abscesses, the recognition of the cause and the removal of the offending tooth being followed by a prompt recovery. I do not care to cite many mistakes of my own, but I cannot forget my mortification once when caught napping by an ulcerated knee, the syphilitic nature of which was indicated and easily demonstrated when a more experienced surgeon asked to see the other leg. On the other hand, I have known lesions to be characterized as syphilitic on what I thought to be an unwarrantable suspicion, and a cross-examination to show that what a patient called a chancre could not possibly have been the initial lesion of syphilis. Now, such errors should not be passed over, or hushed up, when we are speaking among ourselves, or we shall miss the advantage of being taught the necessity for constant vigilance and thoroughness in examining our patients. Of course, this is not the place to discuss the diagnosis of various lesions; but it may be worth while to call attention to the importance of making our

examination include, not only the part believed by the patient to be injured, but also the surrounding parts—muscles, bones or joints, as the case may be—for some distance above and below. The opposite and corresponding parts should often be looked at, for purposes of detection or comparison. Nor should we hesitate to call to our aid the probe or the exploring needle, both of which are valuable and harmless instruments in judicious hands. Two little points, in regard to the sinuses of the face, I would like to speak of. One is the well enough advocated examination of the teeth, by inspection and tapping, to detect a state of abscess in the alveolus; the other I do not remember to have seen recommended. This is, to test a suspected salivary fistula by bringing a drop of the discharge into contact with a drop of the tincture of chloride of iron on a white surface—a piece of white paper will do—when, if the discharge contain saliva, it will give the pink color which indicates the presence of the sulphocyanide of potassium, a normal ingredient of saliva. And, before dismissing this subject, I think a word may be said as to the failure, when one is really at a loss, to get the opinion of some one who is more familiar with our subject than we are. However proper the motives may appear which lead to this, they cannot avert from the patient the consequences of error or delay in diagnosis or treatment; and I believe it would be greatly to the advantage of our patient and ourselves, if we accustomed them to the idea of having a consultation before a case becomes extreme. 1

#### 2. THE CLEANSING OF WOUNDS.

My own experience has led me to the belief that this salutary proceeding is sometimes overdone. When we see a scalp-wound, or a laceration of the face, covered with a scab, even though it be not a very handsome one, good surgery does not, I think, require us to take it off, unless the appearance of the neighboring parts indicates that an inflammatory process is going on under it. Nor, when a crushed finger is enveloped in dry covering of blood and machinery grime, need we think our patient's safety depends upon a thorough removal of these. On the contrary, I should say his rapid recovery often depends upon our letting them alone. But scabs that cover pus may always be removed with advantage; and foul secretions, or accumulations, can only do harm, and must be cleaned out. So the cleansing of wounds is not only an æsthetic, but also a salutary, procedure. As to the method of cleansing, I am a convert to the views of Mr. Sampson Gamgee, who never uses a liquid for cleansing when it is not specially indicated. Careful mopping with dry cotton or lint will do far more than those who have not tried it would imagine. Rubbing is rarely called for, but just touching with the cotton or lint, and pressing it down with more or less firmness, as the circumstances require. But, when the case demands it,

we must not hesitate to rub firmly, even a little roughly, or to pick off or cut off what sticks tight to the healthy tissues. However, we should not eschew the use of water too tenaciously. It is often indispensable, and, combined with a little permanganate of potash—just enough to make a transparent, pink solution—it is a *sine qua non* in dispensary practice, as a disinfectant and deodorant. This combination, it seems to me, excels every other so-called antiseptic; and carbolic acid, I may say, I never use as an antiseptic at all. In this connection, I wish to emphasize what I think is a very important matter in washing of wounds and sores, namely, that the same fluid should never be used twice; that is, it should not be dipped from a basin and allowed to flow from the wound or sore into the same vessel, and then dipped up and used again, and so on. The best way of washing a wound would be to let the water run upon it from a hose with a regulated force. But almost, if not quite, as good as this, is the plan of having one vessel to hold the wash and another to catch the drippings, and to apply the wash by letting it fall in a steady stream from a clean sponge or a mass of oakum. The size of this stream, and its force, can be easily regulated by the force with which the sponge or oakum is squeezed, and the height at which it is held. If the dripping mass be grasped in the hand and held with the thumb up, by well-regulated squeezing a single stream can be made to fall from the dependent portion in exactly the place and way we wish.

### 3. THE CONTROL OF HEMORRHAGE.

An important part of the preparation of a wound for dressing, is the control of hemorrhage—I do not mean the hemorrhage from large vessels, but that from small ones, such as are usually encountered in the surgery of general practitioners. Our colleague, Dr. Roberts, has, I think wisely, deprecated the routine use of styptics, and I quite agree with him that, for almost all small vessels, the pressure of a well-applied dressing will do all that is needed in the way of controlling hemorrhage. Such a dressing may be made of dry lint, bound on with moderate firmness—actual tightness is not called for—and often one will have, in a little while, an imitation of nature's favorite method of healing, by the formation of a scab, made up of dried blood and the tissue of the dressing. The essentials for controlling moderate hemorrhage are dry dressings and moderate compression. Pressure alone is sufficient to control the bleeding from scalp-wounds, which are sometimes spoken of as if they were troublesome to deal with. It is remarkable, at times, to hear men describe the pains they have been at to ligate an artery of the scalp, in view of the fact that this is never indispensable. A compress and a bandage will control any vessel in the scalp, and almost anywhere else; and, if an unruly patient is likely to pull a bandage off, a pin,

even a common one, may be thrust under the vessel and brought out again beyond it, so as to hold it as long as any one could wish. If still greater security be desired, it can be had by adding a "figure 8" to this pin. And here I wish to add a word as to the need for stopping bleeding. I will go a little further than Dr. Roberts in regard to the innocence of hemorrhages which sometimes cause great uneasiness. Many of these hemorrhages are absolutely beneficial. Of course, one need not be foolhardy; but such hemorrhages as come from superficial wounds may be regarded with the greatest equanimity, and no one need get flustered in trying to stop them. In my own experience, I often encourage bleeding to a considerable extent, as in the case of incisions for felons and palmar abscesses, and the like, and have never felt that I lost anything by being deliberate. Hemorrhage from small vessels can often be controlled by a firm pinch with the forceps, or the vessel may be drawn out and twisted round several times. This will often obviate the necessity for ligatures, in operations such as circumcision of infants or children. Sometimes the arteries in the fingers will bleed in a most troublesome way. If the bleeding cannot be stopped by pressure or torsion, it can be controlled by a pad of lint and a few circular turns of adhesive plaster. Persistent hemorrhage from an alveolus, in one with a hemorrhage diathesis, I have controlled, when plugging gave only temporary relief, by injecting a fine stream of cool water against the bleeding point. Bleeding from the wound of the palmar arch can, I believe, almost always be controlled by a pad and bandage.

### 4. DRESSING OF WOUNDS.

*Dry Dressing.*—Nature's method of protecting wounds is by the process of scabbing; and when we reflect upon the successful way in which this operates in all the lower animals, and often in man, too, we may wonder that it should be almost a matter of routine to remove scabs in surgical practice. It may gratify our curiosity, it may even aid our study at times, but it is often of no advantage to the patient to remove from a disfigured face, or a cut head, the crusts which are nature's reliable antiseptic dressings. From what I have seen, I believe it is best to leave such crusts undisturbed whenever possible, and if they are objectionable, in an æsthetic sense, simply to cover them with something better looking. Further, it may be said that an artificial scab made with lint, or tarlatan, or thin muslin, and collodion, forms one of the best dressings for simple incised and not a few lacerated wounds, which have ever been devised. In hospital practice, I see many cut heads and simple incised wounds, even after the removal of tumors, which go to a prompt and uninterrupted healing under the first dressing of this sort. Similarly, scabs may be formed by allowing lint to become saturated with the oozing of a wound exposed to

the air. Dry powders, such as earth or bismuth, or calomel, or powdered borax, or boric acid, or iodoform, may also be used to promote the formation of a crust. In all these cases, however, it is important to watch lest the crust bind down offensive discharges, as any scab may do; when this happens, the crust must, of course, be removed, and the wound cleaned. In the case of strumous ulcers and the weak granulations of large burns, I have had the happiest results from setting aside ordinary dressings, and applying a powder in this way. In these latter cases, I have sometimes practiced exposure of the granulating surface to the air until the serous film covering them has coagulated and formed a species of skin over them. And to my astonishment, I have seen such a film actually transformed into thin skin without displacement. This is a fact which I believe does not accord with the accepted laboratory idea of new skin formation; but it is a fact, nevertheless. And I would especially urge upon others this plan of treatment in the class of cases referred to—old burns and strumous ulcers—which are, I believe, often kept open by the ointments and other warm and moist dressings used to promote their healing.

*Water Dressing* is another good dressing, which I believe is too little appreciated. I have seen a number of wounds of the fingers and hands, for example, done by machinery, in which rapid and painless recovery has followed the application of wet lint, which was wetted again as often as convenient, with a lukewarm or cool solution of common borax. Patients with such injuries I have often dressed with cold water, and told them to dip the finger or hand, as the case might be, in a solution of a teaspoonful of powdered borax in a pint of water, warm or cool, as they found more pleasant, without removing the first dressing.

*Lead-water and Laudanum* is but little better than cold water, so far as my experience would indicate; although it is suited to cases that are especially hot and painful. But I believe this ought never to be covered up, as it very often is, with impervious coverings. It is not an uncommon thing for me to see a cut hand, or a contused joint, or a painful fracture, covered with lint soaked in lead-water and laudanum, with a piece of waxed paper over this, and next a bunch of oakum, the whole bound to a splint with many layers of bandage. My inquiries have usually elicited, from patients treated in this way, the most expressive assurances that they had suffered much, often having passed a sleepless night after these dressings were applied; and I have, I think I may say invariably, found that the suffering disappeared when I changed the dressing for a light lint, dipped in lead-water and laudanum, and held in place by a thin, light bandage, so applied as to leave part of the lint exposed to the air and consequently to evaporation of the lotion, with no splint at all, or

the lightest and smallest kind possible. What makes a recent injury hot and air-proof, I have found usually a painful dressing.

*Dilute Alcohol* is another refreshing dressing, if it be allowed to evaporate, and removed at the first sign of pain.

*Carbolized Oil*, which is, perhaps, not such a very common surgical dressing nowadays, I have found to become very quickly offensive, and I now hardly ever use it. If renewed often enough, it is, however, soothing and healing.

*Ointments.*—To discuss fully the ointments in use in simple surgery, would require more time than you have to give me. So I may, perhaps, be justified in stating that the most universally applicable ointment for open wounds which I know of, is one made of equal parts of carbolic acid ointment and oxide of zinc ointment. This has seemed to me to do more good than any other ointment in the case of granulating surfaces, unless they were syphilitic, and in these, I think, mercurial ointments sometimes do better. A little point in regard to the use of ointments is, that they should be confined, as nearly as possible, to the open surface. A piece of lint or muslin should be spread with the ointment, and trimmed down to the exact size of the sore. If spread on the adjacent skin, it will often, after a while, set up an artificial eczema, which is very annoying to a patient.—

*Med. & Surg. Reporter.*

## STANDARD DISINFECTANTS.

*Disinfection of Excreta, etc.*—The infectious character of the dejections of patients suffering from cholera and from typhoid fever is well established; and this is true of mild cases and of the earliest stages of these diseases as well as of severe and fatal cases. It is probable that epidemic dysentery, tuberculosis, and perhaps diphtheria, yellow fever, scarlet fever, and typhus fever may also be transmitted by means of the alvine discharges of the sick. It is therefore of the first importance that these should be disinfected. In cholera, diphtheria, yellow fever, and scarlet fever, all vomited material should also be looked upon as infectious. And in tuberculosis, diphtheria, scarlet fever, and infectious pneumonia, the sputa of the sick should be disinfected or destroyed by fire. It seems advisable also to treat the urine of patients sick with an infectious disease with one of the disinfecting solutions below recommended.

*Chloride of lime*, or bleaching powder, is, perhaps, entitled to the first place for disinfecting excreta, on account of the rapidity of its action. The following standard solution is recommended:

### STANDARD SOLUTION No. 1.

*Dissolve chloride of lime of the best quality in*

soft water, in the proportion of four ounces to the gallon.

Use one pint of this solution for the disinfection of each discharge in cholera, typhoid fever, etc. Mix well, and leave in vessel for at least ten minutes before throwing into privy-vault or water-closet. The same directions apply for the disinfection of vomited matters. Infected sputum should be discharged directly into a cup half full of the solution.

#### STANDARD SOLUTION NO. 2.

*Dissolve corrosive sublimate and permanganate of potash in soft water, in the proportion of two drachms of each salt to the gallon.*

This is to be used for the same purposes and in the same way as Standard Solution No. 1. It is equally effective, but it is necessary to leave it for a longer time in contact with the material to be disinfected—at least an hour. The only advantage which this solution has over the chloride of lime solution consists in the fact that it is odorless, while the odor of chlorine in the sick-room is considered by some persons objectionable. The cost is about the same. It must be remembered that this solution is highly poisonous. It is proper, also, to call attention to the fact that *it will injure lead pipes if passed through them in considerable quantities.*

#### STANDARD SOLUTION NO. 3.

*To one part of Labarraque's Solution (liquor sodæ chlorinata) add five parts of soft water.*

This solution is more expensive than the solution of chloride of lime, and has no special advantages for the purposes mentioned. It may, however be used in the same manner as recommended for Standard Solution No. 1.

The following powder is also recommended for the disinfection of excreta in the sick-room and of privy-vaults, etc. :

#### DISINFECTING AND ANTISEPTIC POWDER.

*One pound of chloride of lime ; one ounce of corrosive sublimate ; nine pounds of plaster of Paris. Pulverize the corrosive sublimate and mix thoroughly with the plaster of Paris. Then add the chloride of lime and mix well. Pack in paste-board boxes or in wooden casks. Keep dry.*

As an antiseptic and deodorizer this powder is to be sprinkled upon the surface of excreta, etc.

To disinfect excreta in the sick-room, cover the entire surface with a thin layer of the powder—one-fourth inch in thickness—and if the material is not liquid pour on sufficient water to cover it.

*Disinfection of the Person.*—The surface of the body of a sick person, or of his attendants, when soiled with infectious discharges, should be at once cleansed with a suitable disinfecting agent. For this, Standard Solution No. 3 may be used.

In diseases like small-pox and scarlet fever, in which the infectious agent is given off from the en-

tire surface of the body, occasional ablutions with Labarraque's Solution, diluted with twenty parts of water, will be more suitable than the strong solution above recommended.

In all infectious diseases the surface of the body of the dead should be thoroughly washed with one of the standard solutions above recommended, and then enveloped in a sheet saturated with the same.

*Disinfection of Clothing.*—Boiling for half an hour will destroy the vitality of all known disease germs, and there is no better way of disinfecting clothing or bedding which can be washed than to put it through the ordinary operations of the laundry. No delay should occur, however, between the time of removing soiled clothing from the person or bed of the sick and its immersion in boiling water, or in one of the following solutions ; and no article should be permitted to leave the infected room until so treated.

#### STANDARD SOLUTION NO. 4.

*Dissolve corrosive sublimate in water in the proportion of four ounces to the gallon, and add one drachm of permanganate of potash to each gallon to give color to the solution.*

One fluidounce of this standard solution to the gallon of water will make a suitable solution for the disinfection of clothing. The articles to be disinfected must be thoroughly soaked with the disinfecting solution and left in it for at least two hours, after which they may be wrung out and sent to the wash.

*Solutions of corrosive sublimate should not be placed in metal receptacles,* for the salt is decomposed and the mercury precipitated by contact with copper, lead, or tin. A wooden tub or earthen crock is a suitable receptacle for such solutions.

Clothing may also be disinfected by immersion for two hours in a solution made by diluting Standard Solution No. 1 with nine parts of water—one gallon in ten. This solution is preferable for general use, especially during the prevalence of epidemics, on account of the possibility of accidents from the poisonous nature of Standard Solution No. 4. When diluted as directed this solution may, however, be used without danger from poisoning through the medium of clothing immersed in it, or by absorption through the hands in washing. A poisonous dose could scarcely be swallowed by mistake, owing to the metallic taste of the solution, and the considerable quantity which would be required to produce a fatal effect—at least half a pint.

Clothing and bedding which cannot be washed, may be disinfected by exposure to dry heat in a properly constructed disinfecting chamber for three or four hours. A temperature of 230° F. should be maintained during this time, and the clothing must be freely exposed—i. e., hot folded or arranged in piles or bundles, for the penetrating power of dry heat is very slight.

The limitations with reference to the use of dry heat as a disinfectant are stated in a "Preliminary Report of the Committee on Disinfectants," published in the *Medical News*, March 14, 1885.

The temperature above mentioned will not destroy the *spores* of bacilli—*e. g.*, of the anthrax bacillus, but is effective for the destruction of all disease germs which do not form spores; and there is good reason to believe that this list includes small-pox, cholera, yellow fever, diphtheria, erysipelas, puerperal fever, and scarlet fever (?) Moist heat is far more effective, and it is demonstrated that ten minutes exposure to steam, at a temperature of 230 F., will destroy all known disease germs, including the most refractory spores.

In the absence of a suitable disinfecting chamber, it will be necessary to burn infected clothing and bedding, the value of which would be destroyed by immersion in boiling water, or in one of the disinfecting solutions recommended.

*Disinfection of the Sick-room.*—In the sick-room no disinfectant can take the place of free ventilation and cleanliness. It is an axiom in sanitary science that *it is impracticable to disinfect an occupied apartment*; for the reason that disease germs are not destroyed by the presence in the atmosphere of any known disinfectant in respirable quantity. Bad odors may be neutralized, but this does not constitute disinfection in the sense in which the term is here used. These bad odors are, for the most part, an indication of want of cleanliness, or of proper ventilation; and it is better to turn contaminated air out of the window, or up the chimney, than to attempt to purify it by the use of volatile chemical agents, such as carbolic acid, chlorine, etc., which are all more or less offensive to the sick, and are useless so far as disinfection—properly so-called—is concerned.

*When an apartment which has been occupied by a person sick with an infectious disease is vacated, it should be disinfected.* But it is hardly worth while to attempt to disinfect the atmosphere of such an apartment, for this will escape through an open window and be replaced by fresh air from without while preparations are being made to disinfect it. Moreover, experience shows that the infecting power of such an atmosphere is quickly lost by dilution, or by the destruction of floating disease germs through contact with oxygen, and that even small-pox and scarlet fever are not transmitted to any great distance through the atmosphere; while cholera, typhoid fever, and yellow fever are rarely, if ever, contracted by contact with the sick, or by respiring the atmosphere of the apartments occupied by them.

The object of disinfection in the sick-room is, mainly, the destruction of infectious material attached to surfaces, or deposited upon window-ledge, in crevices, etc. If the room has been properly cleansed and ventilated while still occu-

pied by the sick person, and especially if it was stripped of carpets and unnecessary furniture at the outset of his attack, the difficulties of disinfection will be greatly reduced.

All surfaces should be thoroughly washed with a solution of corrosive sublimate of the strength of one part in 1000 parts of water, which may be conveniently made by adding four ounces of Standard Solution No. 4 to the gallon, or one pint to four gallons of water. The walls and ceiling, if plastered, should be whitewashed with a lime wash containing the same proportion of corrosive sublimate, or they may be brushed over with the aqueous solution. Especial care must be taken to wash away all dust from window-ledge and other places where it may have settled, and to cleanse thoroughly crevices and out-of-the-way places. After this application of the disinfecting solution, and an interval of twenty-four hours or longer for free ventilation, the floors and wood-work should be well scrubbed with soap and hot water, and this should be followed by a second more prolonged exposure to fresh air, admitted through open doors and windows.

Many sanitary authorities consider it necessary to insist upon fumigation with sulphurous acid gas—produced by combustion of sulphur—for the disinfection of the sick-room. As an additional precaution, this is to be recommended, especially for rooms which have been occupied by patients with small-pox, scarlet fever, diphtheria, typhus fever, and yellow fever. It should precede the washing of surfaces and free ventilation above recommended. But fumigation with sulphurous acid gas alone, as commonly practised, cannot be relied upon for the disinfection of the sick-room and its contents, including bedding, furniture, infected clothing, etc., as is popularly believed. And a misplaced confidence in this mode of disinfection is likely to lead to a neglect of the more important measures which have been recommended. In the absence of moisture the disinfecting power of sulphurous acid gas is very limited, and under no circumstances can it be relied upon for the destruction of spores. But exposure to this agent in sufficient quantity, and for a considerable time, especially in the presence of moisture, is destructive of disease germs, in the absence of spores. It is essential, however, that the germs to be destroyed shall be very freely exposed to the disinfecting agent, which has but slight penetrating power.

*To secure any results of value, it will be necessary to close the apartment to be disinfected as completely as possible by stopping all apertures through which the gas might escape, and to burn not less than three pounds of sulphur for each thousand cubic feet of air-space in the room.* To secure complete combustion of the sulphur it should be placed, in powder or in small fragments, in a shallow iron pan, which

should be set upon a couple of bricks in a tub partly filled with water, to guard against fire. The sulphur should be thoroughly moistened with alcohol before igniting it.

*Disinfection of Privy-vaults, Cesspools, etc.*—When the excreta—not previously disinfected—of patients with cholera or typhoid fever, have been thrown into a privy-vault this is infected, and disinfection should be resorted to as soon as the fact is discovered, or whenever there is reasonable suspicion that such is the case. It will be advisable to take the same precautions with reference to privy-vaults into which the excreta of yellow fever patients have been thrown, although we do not definitely know that this is infectious material. Disinfection may be accomplished either with corrosive sublimate, or with chloride of lime. The amount used must be proportioned to the amount of material to be disinfected.

*Use one pound of corrosive sublimate for every five hundred pounds—estimated—of fecal matter contained in the vault, or one pound of chloride of lime to every thirty pounds.*

Standard Solution No. 4, diluted with three parts of water, may be used. It should be applied—the diluted solution—in the proportion of one gallon to every four gallons—estimated—of the contents of the vault.

If chloride of lime is to be used, one gallon of Standard Solution No. 1 will be required for every gallon—estimated—of the material to be disinfected.

All exposed portions of the vault, and the wood-work above it, should be thoroughly washed down with the disinfecting solution.

To keep a privy-vault disinfected during the progress of an epidemic, sprinkle chloride of lime freely over the surface of its contents daily. Or, if the odor of chlorine is objectionable, apply daily four or five gallons of Standard Solution No. 2, which should be made up by the barrel, and kept in a convenient location, for this purpose.

*Disinfection of Ingesta.*—It is well established that cholera and typhoid fever are very frequently, and perhaps usually, transmitted through the medium of infected water or articles of food, and especially milk. Fortunately we have a simple means at hand for disinfecting such infected fluids. This consists in the application of heat. *The boiling temperature maintained for half-an-hour kills all known disease germs.* So far as the germs of cholera, yellow fever, and diphtheria are concerned, there is good reason to believe that a temperature considerably below the boiling point of water will destroy them. But, in order to keep on the safe side, it is best not to trust anything short of the boiling point (212° F.) when the object in view is to disinfect food or drink which is open to the suspicion of containing the germs of an infectious disease.

During the prevalence of an epidemic of cholera it is well to boil all water for drinking purposes. After boiling, the water may be filtered, if necessary, to remove sediment, and then cooled with pure ice, if desired.

A sheet of filtering paper, such as druggists use, and a glass or tin funnel, furnish the best means for filtering water on a small scale for drinking purposes. A fresh sheet of paper is to be used each day.—*Med. News.*

## A NEW TREATMENT OF SCIATICA.

Every physician in general practice must have at different times realized how unsatisfactory are all the modes of treating sciatica. Anodynes have failed, or are required in doses so large and frequent as to be a source of danger to the patient. All the machinery of the revulsive medication, from rubefacient terebinthine liniments to linear vesication, the actual cautery, or punctiform (Paquelin) cauterizations, have been brought to bear upon the suffering member. Electricity in all its forms has been tried and frequently proved disappointing. Local anodynes (solutions of menthol, belladonna, ether spray, chloroform) may have rendered some fleeting service. The general tone of the organism has been fortified by quinine, and the quality of the blood improved by iron and cod-liver oil, but the vitality of the *locus minoris resistentiæ* (that "greatest and worst nerve of the body," as we have heard patients say) still remains depressed. Anti-rheumatics have been tried from salicylate of sodium to colchicum and iodide of potassium, all to the point of tolerance, but all to little effect. Nerve-stretching remains, but that somewhat delicate and difficult operation has been reserved as a last resort. In view, then, of the want of success which has attended the old methods, a new method of treatment which promises comfort to physician and patient will be welcomed.

Devobe has lately proposed refrigeration by chloride of methyl in sciatica, as a medication of singular efficacy. This substance, which is obtained by distilling together methyl alcohol, sodium chlorate, and sulphuric acid, is a colorless gas, slightly soluble in water, with sweetened taste and odor; when projected on a part of the body from a suitable siphon bottle, it is attended with the production of intense cold, followed by intense smarting, and if the action be sufficiently prolonged, considerable erythema and even vesication. The benefit which is claimed from this remedy would seem to be due not so much to the refrigerant as to the subsequent counter-irritant and vesicant effect. Devobe, in a late number of the *Bulletin Général de Thérapeutique*, thus explains the principle and *modus operandi* of his method:—

"When we employ revulsion under any form



whatever (vesication, punctiform cauterization, etc.) for a neuralgic affection, we act on certain of the sensory extremities of the painful nerve, but we respect a far greater number of these nerve terminations because it is not possible to multiply to any great extent our vesicatories and cauterity points. A process of revulsion which may be extended to the totality of the member innervated by the affected nerve will be then of far greater efficacy. This process I have realized in employing, as a revulsive, *congelation*. To this end I have had recourse to chloride of methyl, which is readily obtainable in commerce, and with which you may produce a speedy refrigeration. I practise with this agent, using for the purpose a siphon bottle furnished with suitable stop-cock and beak, pulverizations along the diseased nerve, directing the spray especially upon the *points douloureux*. This spraying ought not to last longer than a few minutes. It is much less disagreeable than the actual cautery, and (what is more important) *it is followed by instantaneous relief of pain*. I have by this means cured patients who long had been sufferers, and who had obtained only partial relief from other revulsives. Ordinarily one séance suffices to cause the pain to completely disappear; sometimes, nevertheless, a second séance is necessary; but always after the first séance the pains are considerably lessened. When you prolong the spraying a little too long, you produce vesication. Although this is an accident of little importance, I think it better to guard against it, and as a precautionary guide, I habitually consult the feelings of the patient; when they tell me that the sensations which they experience resemble the pain which the punctiform cautery would occasion, I cease the pulverization."

This mode of treatment was lately discussed at a meeting of the Academy of Medicine. Desnos reported four cases of sciatica in which this method was tried; in three it was completely successful. The spraying from a siphon bottle was performed with great precautions, occupying only a few seconds. Rendu has found that a liability to the production of eschars follows the careless or too free use of this new medication: nevertheless, in one or two stubborn instances the most gratifying amelioration, and even cure, resulted. Bucquoi finds the methyl chloride a revulsive rather than an anodyne; in one rebellious case in his practice it was signally beneficial. Sevestre claims to have cured one inveterate case of sciatica after daily applications for two months of the methyl spray. Legroux has also found spraying with this substance useful in the intercostal neuralgias of tuberculosis. Robin, in December, obtained a striking cure by this means, in a patient forty years of age who had for six months suffered from sciatica with atrophy of the limbs; he was cured after two applications of the methyl, which were followed by vesication and intense pigmentation of

the congealed region. Letulle has treated two patients by the same process; the one was affected with sciatica from neuritis, and was completely cured; the other, who was suffering from Pott's disease, complained constantly of diffuse lumbar pains, and derived the greatest benefit from the methyl-chloride spray.

It is to be hoped that the favorable experiences of these French practitioners with this new remedy may be followed by equally good results in this country, and that this painful, inveterate malady may become less of an opprobrium to medicine and surgery.—*Boston Med. Journal*.

### HEAT AS A DISINFECTANT.

Dr. George H. Rohe gives the following in the *Medical News* regarding dry heat as a disinfectant: The first accurate observations on the disinfecting power of dry heat were made by Henry, of Manchester, in 1831. (Quoted in E. Vallin: *Traité des désinfectants*, Paris, 1882, p. 226). Henry exposed (fresh?) vaccine virus to temperatures varying from 50° to 82° Cent. (122°–180° Fahr.) for two, three, and four hours, and secured complete disinfection, none of the specimens of vaccine thus exposed producing vaccinia when subsequently inoculated. Exposure for three hours to a temperature of 49° C. (120° F.) failed to disinfect. No contra experiments with non-disinfected virus was made by this observer.

E. B. Baxter *Report Medical Officer of Privy Council*, etc., N. S., No. vi., p. 216) exposed dry vaccine to a temperature of from 90°–95° C. (194°–203° F.) for thirty minutes. Disinfection was complete. Vaccination with disinfected virus was unsuccessful. Contra inoculations with non-disinfected virus were successful.

Koch and Wölflhügel (*Mitt. a. d. Kais. Gesundheitsamte*, Bd. I.) experimented with a large number of pathogenic and non-pathogenic organisms. A temperature varying from 78°–123° C. (172°–253° F.) maintained for one hour and a-half (over 212° F. for an hour) sufficed to kill micrococcus prodigiosus and the bacilli of septicæmia of mice and rabbits, but failed to destroy the spores of bacillus anthracis and of various non-pathogenic bacteria and fungi. Micrococci and bacilli containing no spores, and spores of mould fungi, were completely killed by one and a-half hour's exposure to a temperature of from 120°–128° C. (248°–262° F.); but spores of *B. subtilis*, *B. anthracis*, and of a bacillus growing upon potato, resisted a second heating to the same temperature for a similar length of time.

These authors further experimented upon a number of organisms disposed in various ways in the disinfecting chamber, so as to approach in a measure the conditions of practical disinfection. Some of the articles were placed in coat pockets,



others rolled up in balls of cotton, oakum, blankets, or soiled clothing, making packages of different thickness and density. The organisms consisted of micrococcus prodigiosus, micrococcus of blue pus, bacillus anthracis, and bacilli found in garden soil. With each package was placed a registering thermometer to indicate the highest temperature reached during the experiment. The temperature in the chamber varied from  $133^{\circ}$  to  $156^{\circ}$  C. ( $271^{\circ}$ – $313^{\circ}$  F.), and the exposure was continued for three hours and ten minutes. The temperatures in the different packages varied from  $74.5^{\circ}$  C. ( $167^{\circ}$  F.) to  $121.5^{\circ}$  C. ( $251^{\circ}$  F.). In none of the packages were the spore-bearing organisms destroyed. In a small iron vessel hanging free in the chamber and containing specimens of the same organisms, a temperature of  $139.5^{\circ}$  C. ( $283^{\circ}$  F.) was indicated by the thermometer. Here complete disinfection had taken place.

Another series of observations with the temperature in the chamber varying from  $131^{\circ}$ – $140^{\circ}$  C. ( $267^{\circ}$ – $284^{\circ}$  F.), and exposure continuing for three hours, resulted as follows: The organisms (micrococcus prodigiosus, spores of bacillus anthracis, and of bacilli of garden soil) and registering thermometers were enclosed in packages of clothing, bedding, and rolls of blankets. Complete destruction of the spore-bearing organisms did not follow unless the temperature of  $139^{\circ}$  C. ( $282^{\circ}$  F.) had been reached. In one large package consisting of nineteen blankets, thoroughly dried and rolled up, the heat did not penetrate to the interior in a sufficiently high degree to destroy the vitality of micrococcus prodigiosus even.

He submits the following conclusions:

1. A temperature of  $100^{\circ}$  C. ( $212^{\circ}$  F., dry heat), maintained for one hour and a-half, will destroy bacteria which do not contain spores.
2. Spores of mould-fungi require for their destruction in hot air, a temperature of from  $110^{\circ}$ – $115^{\circ}$  C. ( $230^{\circ}$ – $230^{\circ}$  F.) maintained for one hour and a-half.
3. Bacillus spores require for their destruction in hot air a temperature of  $140^{\circ}$  C. ( $284^{\circ}$  F.), maintained for three hours.
4. In dry air the heat penetrates objects so slowly that small packages, such as a pillow or small bundle of clothing, are not disinfected after an exposure of from three to four hours, to a temperature of  $140^{\circ}$  C. ( $284^{\circ}$  F.).
5. Exposure to a temperature of  $140^{\circ}$  C. ( $284^{\circ}$  F.) in dry air for a period of three hours injures most objects requiring disinfection (clothing, bedding, etc.) to a greater or less degree.

MARTIN'S METHOD OF TREATMENT OF SYNOVITIS, ESPECIALLY OF THE KNEE-JOINT.—During the past thirty-one years over four hundred cases of synovitis of the knee and its sequelæ, of every

form and degree of severity, in every variety of diathesis and complication, however chronic or acute, have been treated by the use of the pure rubber or "Martin" bandage—applied to the limb from the foot to above the knee. The joint is previously strapped from three inches above to a corresponding point below the patella, with non-irritating rubber plaster. This strapping is not applied for the ordinary reasons, but to obviate, or at least mitigate, a troublesome chafing of the skin in the popliteal space, from walking exercise while the bandage is on the limb. One such strapping will remain *in situ* for four or five weeks, and in a very large proportion of cases has not to be repeated. The plaster, however, must be perfectly non-irritating. The bandage should be applied as tightly as the patient can wear it with comfort. There is no danger of the circulation by following this rule, as no dangerous constriction of the limb could be endured without pain and discomfort. The bandage thus applied should be worn in general for from four to six weeks, according to the severity of the case, day and night; and, after that, during the day only, or while in the upright position, for from four to eight weeks longer. Many patients prefer to wear them a good deal longer, to prevent any possible return of trouble, but this is in general not at all necessary.

When the bandages are thus applied, great comfort and support are at once experienced, and with these much increased capacity to use the joint. Very soon it becomes evident that absorption of effused fluid, and of the interstitial deposits in the tissues of the synovial sac, and of the other tissues about the joint, is going on; and, in a space of time too short to be credible to those who have not accurately pursued the practice, and carefully and repeatedly observed the fact, the enlarged and weakened articulation is restored to the normal size, and if not immediately to its original strength, to a far greater capacity for use, and eventually to a perfect restoration in all respects.

In cases where the amount of fluid effusion within the sac is small, or where the thickening of the sac is the principal element of the case, these results may be always looked for with certainty and rapidity. Sometimes, however, when the amount of fluid effusion is very large, the use of the bandage *alone* (although of the greatest value as a palliative, by strengthening the joint, and permitting painless use of the limb) will produce *complete* absorption of the fluid very slowly, if at all. The existence of these exceptional obstinate cases induced my father, some twelve years ago, to add to the use of the bandage a preceding thorough aspiration of the sac, all the other points of treatment being exactly as before described. This was done at first only in exceptionally obstinate cases, in which the effusion within the synovial sac was large, but the operation was gradually found to be

entirely free from danger, and latterly aspiration has been practiced in all cases in which, being chronic, the synovial effusion is of any considerable amount, and even in the most acute cases in which rapid effusion produces great distention and consequent pain.

The results of my father's experience are summed up in the following statements:

1. In the last twelve years over two hundred cases of synovitis of the knee, and its sequelæ, have been treated by aspiration with a single strapping of the joint, and subsequent use of the bandage.

2. In these cases the knee-joint has been punctured over four hundred times.

3. In all these cases, with the exception of a very few, and these only in the early stages of treatment, the patient was not only permitted, but obliged to take a daily and considerable amount of walking exercise.

4. In not a single instance has there been failure of absolute and entire cure, requiring, in one case, seventeen weeks, but in no other more than eleven weeks.

5. Although no antiseptic measure, beyond perfect cleanliness of the aspirating needle, was employed, in not one instance has any ill symptom followed the operation. When the needle is withdrawn, the puncture is at once covered securely with adhesive plaster.

Sir Benjamin Brodie long ago declared most emphatically, that when the synovial sac is distended with fluid, it can be punctured, and the effusion drawn off with perfect safety. He does not by any means regard this as a help in treatment, however, as he says the fluid will accumulate again, and in a few hours the joint will be as much distended as before. The originality and value of my father's method of treatment lies in successfully demonstrating the fact that thorough aspiration of the knee-joint, followed by proper use of the rubber bandage, gives us a complete and satisfactory method of cure even in the worst cases of synovitis. By the firm and equable pressure of the rubber bandage, the re-accumulation of fluid is checked. If there is any return of the fluid at all, it is in very much diminished quantity, and a second, or perhaps in severe cases a third, aspiration of the joint is all that is ever required. One great advantage of it is to explode the idea that perfect rest of the joint is the only way to hope for a cure. The patient is emphatically *not* to be confined to bed, or, worse still, to a fixed splint. When the joint is strengthened by a properly applied rubber bandage, exercise is a very great and important adjunct in the treatment. This very day I have visited a lady who passed last summer in Switzerland. While there she was attacked with synovitis of the left knee, with a large amount of effusion into the sac. She was kept in bed,

with the limb placed on a fixed splint and continually poulticed. After sweltering through the hot weather with the limb swathed in many thicknesses of cotton wadding, at the expiration of two months the splint was removed, and—she has come home with a joint almost immovable! I am sure that had this case been treated by prompt aspiration of the sac, and the proper use of the rubber bandage, a perfect and rapid cure would have resulted without a week's confinement of the patient to her bed.—*Medical Record*.

AMPUTATIONS AND EXCISIONS.—Speaking of amputations, Mr. Banks, of Liverpool, *Med. Record* (N.Y.) naively remarks that for his part he only knows and only teaches two things about them, viz., to make one flap longer than the other and to saw the bone as low down as possible. I may remark that the size of the flaps is a question on which surgeons differ greatly. Many British surgeons are now in favor of having two flaps of nearly equal size. The "circular" method has also many advocates.

In amputating through the femur for disease of the knee-joint it is difficult, says Mr. Banks, to see any use in keeping the patella. Sawing off its cartilaginous surface and then trying to make it stick on to the cut end of the femur may afford an operator of a mechanical turn of mind some amusement, but nothing more. It is not the patella we want, but the hard skin over it.

In describing a case of double amputation for railway injuries, Mr. Banks alludes to rapidity of operating as an element in prognosis. In this case the patient, a boy of ten years of age, had fallen from a train and lay in a tunnel all night in severe wintry weather. He was apparently dead when brought to the hospital, but some signs of life appeared after a time. Subcutaneous injections of ether were given him (two of thirty minims each) and "he was placed on a mattress opposite a large fire and literally cooked into life again." Reaction had fairly set in by the evening. He was then taken into the theatre, "the smallest whiff of ether" was given him, while the two injured limbs were removed "with all the rapidity possible." Rough dressings of lint soaked in carbolic oil were applied, and the patient "was again in the ward on the mattress before the fire in less than fifteen minutes from the time of his removal." Space fails me to give the full history of this most interesting case, but I may say that the patient was attacked with "surgical scarlet fever," the urine became albuminous, the flaps opened up and refused to heal, and the bones protruded. The patient eventually recovered, a result largely due, Mr. Banks believes, to the speed with which the operations on him were performed. He remarks that in these days of æsthetics the surgeon is apt to proceed too deliberately, forgetting that the patient, though not suffer-

ing pain is suffering shock—that “every minute of anæsthesia, every fresh incision, every lost teaspoonful of blood,” lessens his chance of recovery. Mr. Banks goes so far as to say that in a thigh amputation for smash, the fact of the patient being on the table twenty minutes in one case, or forty-five in another, makes all the difference “between his crossing the bar and sticking on it.” In the case just alluded to, the warm fire, subcutaneous injections of ether, the selection of ether as an anæsthetic, and the careful use of antiseptics, all no doubt aided in procuring the favorable result.

Mr. Banks is a warm advocate of ether as an anæsthetic, and even goes so far as to say, “To-day it has elbowed chloroform out of the field.” This may be so in Liverpool; it certainly is not so in London. Chloroform is still largely used both in hospital and private practice. The A.C.E. mixture is becoming more generally used also. Local anæsthesia is becoming more largely employed. Ether-spray, or ice and salt, is much more often made use of for minor operations than formerly. The introduction of cocaine has stimulated investigators to try and discover some other local anæsthetizing agent. Mr. Banks recognizes two objections to ether. One, the danger of excessive secretion of mucus in bronchitic patients; the other, its failure to thoroughly control muscular action even after feeling is abolished.

Mr. Banks has some very thoughtful remarks to make on the subject of excisions. At the International Medical Congress in London (1881) Mr. Howard Marsh ignored statistics and pointed out that excision belongs to the same class of treatment as amputation. It is giving up the attempt to cure the disease. To this view Mr. Banks cordially assents. Far better than advocating early excision is it, he says, to devote ourselves to teaching the early recognition of hip and joint disease. “The children of rich people,” he says, “don’t have their hips and knees excised. Why not? Because the articular mischief is promptly found out, and skillfully and patiently treated.” Joint diseases are so prevalent in the cold and damp climate of Liverpool, that Mr. Banks’ opinion is worth hearing at any rate. I may remark that the Clinical Society’s report (1881) on excision of the hip-joint, showed a mortality of thirty-five per cent. in cases of excision as against thirty in cases of supuration treated by rest and extension.

Mr. Banks says the following is his teaching to students: “In children up to fifteen years of age, if you get a case of knee or hip disease from its commencement, make up your mind to save the limb. You ought to save it. Between fifteen and twenty-five, failure is to be looked for very often, and then you may excise. Don’t operate until your art is exhausted—only don’t wait until your patient is exhausted. Fortunately after twenty-five or thirty, joint mischief is not common; but

at that age whatever you may do with the hip, do not excise the knee, if your patient will let you amputate.”

Mr. Banks says that his impression of excision of the knee-joint after thirty years of age is that it is, as a rule, disastrous, and that many a life has been lost to save a leg. On this question many surgeons will be disposed to join issue with Mr. Banks, but one remark that he makes is certainly worth remembering. It is that a workingman does not usually do a stroke of work on an excised knee-joint under eighteen months or two years; after amputation he is at work in from four to six months on a sound stump.

**CASE OF CÆSAREAN SECTION PERFORMED BY THE PATIENT HERSELF.**—The following remarkable case was related by Dr. von Guggenberg, and the patient exhibited, at the last annual meeting of Bohemian physicians at Tetschen. On September 28, 1876, he was summoned at two in the morning to see a woman, who was said to have cut open her abdomen. He found the patient lying in a miserable house, on a wretched and dirty bed, exhausted and bloodless, and only capable of making affirmative and negative signs. On removing a dirty petticoat which covered her, an incised wound was seen on the right side of the abdomen, passing downward and inward, from which a somewhat large coil of intestine protruded, the greater part of which, covered with dried blood, rested upon a dirty blood-soaked straw sack. Hæmorrhage seemed to have ceased from every part of the wound, and the uterus was contracted to the size of a child’s head. A fully developed, but dead, male child lay between the patient’s knees. Clean linen was procured from a neighboring house, and, with a piece soaked in oil, the protruded intestines were carefully wiped and returned, and the wound sewed up, the peritoneum being included with the skin. The incision was about three and a half inches long, and slightly S-shaped. It was dressed with a five-per-cent carbolic solution, fixed with strapping, and the abdomen was carefully bandaged. By the afternoon, the patient was able to speak, and next day the history was taken. She had had seven children previously, four of whom had been born without medical assistance, two with forceps, and one after craniotomy. The pains began between September 24th and 25th, ceased in the afternoon, and came on again on September 26th, when the midwife stated that she felt the presenting head on vaginal examination. On September 27th, convulsions came on, according to the patient’s account, accompanied by agonizing pain and great distension of the abdomen, the movements of the child ceasing. The pain and distension became so severe that the patient determined to perform Cæsaean section, of which she had heard. She therefore took a razor and divid-

ed the skin slowly; she then made a second and a third incision; and finding the child not yet appearing, made another cut, which caused a large jet of blood to escape, and exposed the placenta; this she removed. One foot of the child came into view, which she seized and pulled upon until the whole of the body came through the wound, the head requiring the exertion of all her force. She divided the umbilical cord, laid the child (which she believed to be dead) beside her on the bed, and threw the placenta on the floor. She had passed neither urine nor feces since September 24th. The progress of the case was very good; urine was passed on the afternoon of September 28th, but the first stool not till October 2d. The pulse reached one hundred and twenty on the day after the operation, but was never again so frequent; the temperature is stated to have been not very high; and, although there was a considerable amount of exudation from the wound, it had united by October 3d. The patient soon returned to work, and has been ever since in perfect health.—*British Medical Journal*.

**TREATMENT OF GONORRHOEA**—In the early treatment of gonorrhœa, Prof. Gross condemns the use of injections. His plan is as follows: If possible, put the patient to bed; give him at the outset a purge, by administering Epsom and Rochelle salts, each  $\mathfrak{z}$  ij, in lemon syrup. Allow no meat or any stimulating articles of diet, etc. Malt liquors do more harm than alcoholic, so interdict both. No tea or coffee, but give him milk, eggs and some oysters, etc. Three times daily he is to hold the penis in a cup of hot water—quite hot. Keep the organ there for five minutes at a time, then wipe it gently each time.

The internal treatment will be by the "antimonial and saline mixture":—

R. Antimonii et potassii tartrat, gr.  $\frac{1}{6}$   
 Magnesii sulphatis,  $\mathfrak{z}$  ij  
 Morphinae sulphatis, gr.  $\frac{1}{16}$   
 Tinct. aconiti radiceis, gtt. j  
 Liquor. potassii citrat., f  $\mathfrak{z}$  ss  
 Olei limonis, gtt. ss  
 Elixir. simplicis, f  $\mathfrak{z}$  ss. M.

SIG.—Ter die.

By this treatment the urine will be rendered bland and unirritating. Should the urine persist in "scalding," then add to the above prescription gtt. x tinct. cannabis indicæ. To prevent or cure chordee, order at night a suppository of—

R. Extract. opii,  
 Camphoræ, aa gr. iij.

In the course of four or five days the discharge from the urethra will look more like laudable pus; then order an injection:—

R. Hydrargyri chloridi corrosivi, gr. ij  
 Aquæ destillat., O j.

SIG.—With syringe that holds an ounce, inject into the urethra—having first "flushed" the canal several times by voiding urine—and retain the fluid for five minutes.

Internally, a useful combination is that used at the out-door department at the hospital, and consisting of—

R. Cubebæ,  $\mathfrak{z}$  ij  
 Alum. pulv.,  $\mathfrak{z}$  j. M.

SIG.—Of this take a heaping teaspoonful in a tumbler of water ter die; the dose to be increased.

Should the discharge per urethram still persist, use an injection of—

R. Liquor. plumbi subacetatis, f  $\mathfrak{z}$  j  
 Aquæ, f  $\mathfrak{z}$  x. M.

Or—

R. Plumbi acetatis, gr. ij  
 Zinci sulphat., gr. iij  
 Aquæ, f  $\mathfrak{z}$  j. M.

Or—

R. Acidi tannici, gr. ij  
 Aquæ, f  $\mathfrak{z}$  j. M.

—*Coll. and Clin. Record*.

**MONSEL'S IRON IN DIARRHOEA**.—Dr. E. T. Williams (*Boston Med. and Surg. Journal*), says: "Ever since I began practice in 1868 I have been looking for a really satisfactory astringent in chronic catarrh of the bowels. There is, as everyone knows, a class of cases where the ordinary vegetable astringents fail to act, or at least act too feebly to do real good. The intestinal lining is in an ulcerous, or quasi-ulcerous, condition, and requires the potent action of a mineral astringent to treat it, as in cases of external ulcer. The acetate of lead is one of the best remedies in these cases, but cannot be safely given for any great length of time. Oxide of zinc in pill form is safe and efficient, but with children, who must take it in powder, often vomits and gripes. Sulphate of copper and nitrate of silver are still farther, and for children quite out of the question. Subnitrate of bismuth is worse.

"I began trying, in 1876, at the Seashore Home, iron alum (the officinal sulphate of iron and ammonia). I found it better than anything I had previously tried, and have used it freely ever since. It is not quite so well borne by the stomach as lead and bismuth, but far better than zinc or copper. The dose for a child is from one to three grains; for adults, from three to ten. At the Seashore Home we make powders containing one grain of the salt to a twelfth of a grain of opium, giving one or more for a dose according to the age of the child. For adults the pill form is of course preferable. I have had the best results from its use.

"Last summer I began using Monsel's salt in

its place, both in public and private practice. This I did from my experience of its great efficiency as a styptic, and a presumption that it might do equally well in diarrhoea, and have found it even better than iron alum. I have tried it only in the dry form, manufactured by Squibb under the name of pulvis ferri subsulphatis. In this State it is not officinal, though it is precisely the same as the officinal liquid ferri subsulphatis evaporated to dryness. It may be given in the same doses and in the same way as iron alum."

**POPLITEAL ANEURISM SIMULATING SARCOMA.**—The diagnosis of popliteal aneurism is not generally a matter of great difficulty, still some of the cases of aneurism simulate other diseases so closely that mistakes are occasionally made. Many able surgeons have opened aneurisms, supposing them to be abscesses, and others again have tied the femoral artery for malignant growths, mistaking them for aneurisms. There are not a few cases recorded where an old consolidated aneurism has been mistaken for a sarcomatous tumor. In the January issue of the American Journal of the Medical Sciences Dr. Francis J. Shepherd, of Montreal, reports an obscure and instructive case of popliteal aneurism, which was under observation for several weeks, and in which there was a total absence of aneurismal symptoms, and the rational symptoms pointed to sarcoma, either of the periosteum or the parts about an old popliteal aneurism, for which the patient had been successfully treated some years before. Amputation was performed, and an examination of the tumor showed it to be solid throughout and composed of fibrin, solidified *en masse*. The orifice of the aneurism was at the distal end of the tumor, and the blood therefore flowed from below up, with, of course, a lessened stream; the circulation, owing to the obliteration of the femoral above the tumor, being carried on by collateral branches. As there was no cavity in the tumor the absence of pulsation and bruit is explained. As there was not a single symptom which pointed to aneurism an accurate diagnosis seems to have been impossible.—*Louisville Med. News*.

**THE THERAPEUTIC VALUE OF MILK.**—In *L'Union Medicale du Canada*, Dr. H. E. Desrosiers has a very interesting lecture on the above subject. Milk may be used constitutionally and locally. Internally, it is, first of all, a very valuable restorative. It is an article of diet that can be borne when everything else is rejected; and in general the patients like it. It may be used in all diseases characterised by anæmia, debility and asthenia. Among the diseases in which it is most commonly used may be mentioned, idiopathic anæmia, chlorosis, convalescence from debilitating diseases, inflammatory and febrile affections, in cachexias,

etc. M. Dujardin-Beaumetz insists upon a milk diet in tuberculosis.

In the above diseases, a milk diet need not always be prescribed to the exclusion of other food. Milk is expressly indicated in the treatment of certain special diseases, such as irritative dyspepsia, gastric catarrh, gastric ulcer, cancer of the stomach, chronic intestinal indigestion, chronic diarrhoea, especially in children; in acute and chronic nephritis, diabetes mellitus, cystitis (especially chronic), gout, aneurism, and organic disease of the heart. In regard to the last, milk is used with most benefit in the period of non-compensation (the *adynamic* period of Peter). Milk has no appreciable effect in affections with compensatory hypertrophy. The intravenous injection of milk has been proposed in profound anæmia, following hemorrhage, etc.; this treatment has met with a certain degree of success in the hands of most observers.

Locally warm milk is a good gargle in acute pharyngitis and tonsillitis. It has also been recommended in diphtheria.

Sometimes skim-milk is preferred by the patients; and it even seems to be better than pure milk in interstitial nephritis. Skim-milk seems easier to digest in gastro-intestinal disorders. It has been employed with success to reduce obesity. Tyson says that it is better than any other article of diet in glycosuria.

Buttermilk, too, has its adherents; and it seems preferable to pure milk in the treatment of the gastro-intestinal disturbances above mentioned.—*N. O. Med. and Surg. Jour.*

**NEW OPERATION FOR RUPTURED PERINEUM.**—Dr. A. C. Post read a brief paper on this subject before the N. Y. Academy of Medicine. He said that the operation had not been performed a sufficient number of times to entitle it to be regarded as established, but in the three cases in which he had performed it the result had been so satisfactory as to lead him to recommend it to the profession as worthy of trial. The operation was simpler in execution than the one ordinarily performed, and he thought it secured a more solid perineal body, and it also had the advantage that there was no loss of substance in its performance, and consequently it might be easily repeated if for any reason the first operation should fail.

An incision was made each side of the vagina to the depth of fifteen or twenty millimetres. The incisions met in front in a manner to divide the parts into an upper and lower segment. The upper segments were turned up and formed the floor of the vagina, and were secured in position by a row of catgut sutures passed, not through the skin, but through the subcutaneous cellular tissue so as to turn the edges of the skin upward to form a ridge on the floor of the vagina. A second row of sutures, of silver wire, were passed from either side

through the deepest part of the incisions, where the upper and lower segments met. The ends of these sutures were passed through glass beads and perforated shot, and after the flaps were brought into close contact the shot were compressed. The inferior edges were united by fine sutures, and an iodoform dressing was then applied. The integument on the inner side of the thighs should be protected from pressure by the shot and beads. The patient should be allowed to urinate without the use of the catheter, and the parts be washed afterwards with a solution of mercuric bichloride. The sutures might be removed at the end of ten days or a fortnight.—*Med. Times.*

**A NEW ABDOMINAL DRAINAGE TUBE.**—Dr. H. Marion Sims describes the following new abdominal drainage tube in the *N. Y. Medical Journal*: "It acted so nicely and drained the pelvis so well that he wished to call the attention of the medical profession to it. It consists of a large and a small tube made of hard rubber. The smaller tube is inside of the larger one, running along the posterior wall, and terminating about an eighth of an inch from the bottom. The large



tube is perforated on the sides and curved on the top, so that, when in the abdominal wound, the top of the tube projects nearly over the symphysis pubis. The smaller tube is for the purpose of washing out the peritoneal cavity, the water being thrown in at the bottom of the cavity instead of at the top, as in most draining-tubes. He attaches a

small rubber tube at B, and forces the water to the bottom of the tube C with a Davidson's syringe. At the mouth of the tube A he attaches a large rubber tube, and, while washing out, the water runs into a bed-pan or any convenient vessel placed in the bed. Where drainage is constant and very profuse, the rubber tube can be long enough to hang over the side of the bed into some vessel placed there. By having the smaller, or washing-tube project through the dressing on the wound, the pelvic cavity can be washed out without removing the dressing, which will remain dry and clean.

**CHLORAL HYDRATE AS AN ANTISEPTIC.**—Dr. Warner of Worcester, in a communication to the *Boston Medical and Surgical Journal*, states, that, during the last ten years, he has used a solution of chloral (three to five grains to the ounce) as almost his only dressing, and has found it acts admirably; as, while it is inodorous itself, it removes the fœtor of purulent discharges effectually. It is cheap, and simple in its application, and, causing no stain, can be sprinkled freely about. It seems also to act as a local sedative, often so relieving pain of a recent injury or operation as to render resort to an opiate unnecessary. During the treatment of large suppurating wounds, it keeps the air of a ward or room pure; while there is no danger from its absorption, and the comfort from a light compress moistened in the solution is very great. Somewhat frequent changes are required to prevent the compress from becoming dry and sticky, and secure perfect cleanliness. It acts as a perfect germicide, rendering spraying quite unnecessary. In a solution in warm water, the hands of the operator, instruments, sponges, etc., are cleansed. Dr. Warner speaks of his experience of its employment in various operations producing large surfaces, and greatly prefers it to carbolic acid and other antiseptics. Chloral may also be used with cosmoline or glycerine in the same proportions, if there is any reason to prefer this form of preparation.—*Pop. Science News.*

**HOW TO TREAT THE ATTACHMENTS OF UTERINE TUMORS.**—Dr. Thomas Keith, (*Brit. Med. Journal*) says: "I have no one way in dealing with the attachments of uterine tumors. At present each case must be a law unto itself, and of this part of the operation there is much to be learned. A few of the simpler cases may be treated extra-peritoneally. Generally the broad ligament must be left inside, and sometimes the whole attachment, when there is much enucleation, must be so treated. Sometimes the treatment may be entirely intra-peritoneal by means of Kœberlé's *serre-neud*, or it may be half intra- and half extra-peritoneal. These cases require much care in the after dressing, though the convalescence is much shorter than

when the whole is left outside. I am hopeful that the cautery will yet be the safest and best of all the methods of dealing with some of these tumors. The more I use it in ovariectomy the more I like it. It is simply perfect, and its employment seems to me "a higher exercise of our art" than the ligature, which, apart from the chances of hemorrhage, embraces ten times the amount of tissue that is really necessary. That a more perfect way will soon be found I have little doubt. This will do as much for uterine tumors as Baker Brown's intraperitoneal method has done for ovariectomy ever since 1864.

**EXTIRPATION, BY LAPAROTOMY, OF A HYDATID CYST OF THE LIVER.**—Dr. Guttierrez reports this curious case in *El Dictamen (Le Progrès Medical)*. A boy, 8 years of age, suffered from a tumor situated in the right iliac fossa and as large as a foetal head. Capillary puncture gave a clear fluid containing numerous hooklets, which were insignificant. It having been decided to extirpate the tumor, the right side of the abdomen was opened by an oblique incision, and the tumor dissected from its adhesions to the epiploon, of which a portion was also removed to avoid its mortification. After opening the cysts, which had increased rapidly in size after the exploratory puncture, there was discharged with the fluid the great pouch or hydatid, which had as its external envelope the thickened capsule of Glisson, which the hydatid had by degrees disengaged from the external surface of the liver until it had lodged in the iliac fossa; the operator extirpated the fibrous envelope from its hepatic attachment to prevent any supuration that might compromise the result of such a brilliant operation. He then applied three sets of sutures, very fine catgut, including first the peritoneum, then the divided muscles, and, finally, the skin, using Lister's dressings. There was not the slightest trace of peritonitis, but reaction from the effects of the operation was slow; the wound healed perfectly, however, and digestion was normal.—*Fourn. Am. Med. Association.*

**CORROSIVE SUBLIMATE AND GLYCERINE IN EPITHELIOMA OF THE CERVIX UTERI.**—D. Biddle in the *Brit. Med. Journal* says: There are few things in the way of palliative treatment that have given me greater satisfaction than the use, in a case of epithelioma of the cervix uteri, of a lotion, or injection, containing one-fourth of a grain of corrosive sublimate and half an ounce of glycerine, to a pint of water. Before using it, a patient of mine had, for seven or eight months, been subject to paroxysms of agonising pain, and to frequent hæmorrhages, which were occasionally profuse. Immediately upon its employment, and for the last three months of her life, hæmorrhage became merely nominal; and, instead of agonising pain,

there was simply the distress consequent upon irritation (by the tumor) of the bowel and bladder, the latter of which became perforated a week before death. I attribute the beneficial change to the very marked reduction in the amount of infiltration. The lotion was used continuously, with very few exceptions, twice a day during the three months, and I shall certainly adopt the same treatment in the next case I have, even before recovery is despaired of. In the case referred to, it was not tried until the curative effects of chromic acid had been tried in vain.

**CARBONATE OF AMMONIA IN SCARLET FEVER.**—Dr. A. W. Jackson, of Brooklyn, writes calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.—*The Medical Record.*

**TREATMENT OF ZONA.**—Dr. Fabre recommends the following treatment of zona: In the beginning of the disease, mild purgatives may be necessary. These should be followed by general sedatives, such as opium, belladonna, and ether, to diminish the pain. Locally, anodyne liniments may be applied and the diseased parts dusted with subnitrate of bismuth or oxide of zinc. If the vesicles are fresh and transparent, they may be aborted by covering them with collodion; but if they have been present four or five days, application of collodion will have no good effect; but, on the contrary, they will suppurate beneath it. The neuralgia which persists after the cure of the eruption should be treated by hypodermic injection of morphine or atropine, and arsenious acid in doses of from  $\frac{1}{30}$ th to  $\frac{1}{8}$ th of a grain be administered internally.—*L'Union Médicale*, Feb. 26, 1885.—*Med. News.*

**ANTISEPTIC SILK.**—Freeman uses Chinese twist which has rendered a septic by boiling for ten minutes in a two per-cent. solution of chromic acid, and then soaking for twelve hours in a one per-cent. solution of the same. He states that the sutures may be left *in situ* for three weeks without the occurrence of either suppuration or softening of the silk. Silk thus prepared is especially useful in operations about the genital organs in women as well as in laparotomy.—*N. Y. Med. Journal.*



# THE CANADA LANCET.

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## THE USES OF IODOFORM.

Among German surgeons iodoform is more extensively used than any other antiseptic in the treatment of wounds. This substance, while less likely to be followed by toxic effects than carbolic acid, is not entirely free from danger. But whilst its careless use may occasion unpleasant symptoms, one very excellent feature in its favor is its freedom from irritating qualities. It may be applied directly to extensive raw surfaces, or dusted into large abscess cavities, without any fear of provoking irritation, and it is only when used in excessive quantities that danger from poisoning may be apprehended. Unlike carbolic acid, it does not increase the amount of serum from a wound.

The utility and general applicability of iodoform is much impaired by the fact that it is insoluble in water. It cannot therefore be used for irrigation, washing, cleansing, disinfecting instruments and the like. It is soluble in ether, collodion and glycerine in the proportion of about one part to ten of either menstruum, and these solutions may be used for dressing wounds. In the treatment of wounds it is generally used, however, in the form of powder, or gauze in which the meshes are thoroughly impregnated with iodoform by dusting and rubbing with the hands. An ointment of varying strength is also frequently used in the treatment of ulcers. Iodoform has been in use for several years past in the Toronto General Hospital in the treatment of chancroid and syphilitic ulcers, chronic

ulcers, compound fractures and all unhealthy wounds, and the results have been most satisfactory.

Iodoform is used largely by Billroth and others in the Vienna clinics. Iodoform gauze is the favorite application after operations, especially about the face and throat, in compound fractures and resection of joints. Billroth claims that iodoform possesses anti-tuberculous properties in addition to its antiseptic qualities, and consequently employs it freely in all joint diseases of a scrofulous character. After resecting and removing all diseased bone, the cavity is packed with iodoform gauze. The gauze is used in the same way in the treatment of compound fractures and abscess cavities. Strips of the gauze are packed in alongside the fragments of bone, and in abscess cavities, until the space is completely filled, and over this is placed layers of iodoform gauze and this dressing allowed to remain for several days.

One very effectual method of applying iodoform to an ulcer or wound is by atomization, by means of a spray producer, of an ethereal solution made by dissolving one part of iodoform in from seven to ten parts of ether. Evaporation of the ether takes place in a few minutes, leaving a thin film of iodoform evenly distributed on the surface of the wound. Another very convenient method, when it is desirable to introduce it into a sinus, or abscess cavity, is to inject a solution of one part of iodoform to ten of glycerine, after the cavity has been well washed out. Gynecologists have for some years past been in the habit of using iodoform as an antiseptic coating for uterine tents, also in cases of endometritis, puerperal septicæmia, and as a palliative and to correct the fœtor of the discharges in cancer of the uterus and rectum. It is not only valuable in removing the fœtor, but also in alleviating the pain and suffering in these distressing affections.

The internal use of iodoform is somewhat limited. Within the past year or two it has been used in the treatment of secondary and tertiary syphilis, when iodide of potassium could not well be borne. We have in our own experience seen some benefit derived from its internal administration in chronic ulcer of the stomach. It has also been used with indifferent success in chronic diseases of the lungs. The dose is from one-half to three grains in the form of a pill.

## RESORCINE IN WHOOPING-COUGH.

This remedy has been extensively employed during the last year in the treatment of whooping-cough, with more or less success. Dr. Moncorvo, of Rio de Janeiro, was among the first to bring the treatment into general notice. He strongly advocates the topical employment of resorcine in the strength of one per cent, applied by a fine pencil-brush to the larynx. He gives fourteen instructive cases, of various degrees of severity and duration, in which this remedy was found by him highly serviceable. He gives the following conclusions:

1. That whooping-cough—whose nature, up to a very recent period, has been subjected to the most diverse interpretations, in relation to its genesis—may, to-day, according to the latest microscopic researches, be included in the class of parasitic diseases.

2. That the disease appears attributable to the presence of micrococci which multiply prodigiously in the hyperglottic vicinity of the larynx, infiltrating its epithelial cells, which appear to be the predilective seat of their development.

3. That resorcine, applied to the laryngeal mucous membrane, caused, in all the cases in which it was employed, rapid decrease of the number of paroxysms, moderation of their intensity, and finally recovery in a short period of time, without the aid of any other medication.

Dr. Moncorvo says that resorcine, owing to its less caustic action, and the absence of disagreeable taste and odor, is far preferable to carbolic acid. He has administered it internally to children, even the newly born, suffering under diarrhoea and dysentery. He advises that strict attention be given to the quality, so as to secure the article in purity; and he recommends that prepared by Monnet, of Geneva, which is of notable whiteness, and in the form of silvery bright crystalline needles. It is extremely soluble in water. Dr. M. recommends the topical application with the fine pencil-brush, to be repeated every two hours. The first applications, he says, sometimes exacerbate the coughing fits, but this irritation ceases in two or three days. In twenty cases treated by him, he was not disappointed in his expectation in a single instance; and some of them had been very obstinate, or even dangerously complicated, as with hereditary

syphilis, threatened hydrocephalus, pulmonary tuberculosis, intermittent fever, etc.

Resorcine, in its source, being a congener of carbolic acid, no doubt acts in a similar manner as a parasiticide. Dr. Moncorvo states that he has, by numerous microscopic examinations of sputa expectorated by his patients laboring under whooping-cough, verified the statements made by Letzerich, Henke, Steiner, Hagenbush, and other writers, as to the parasitic character or complications of the disease. The treatment advocated by him is, therefore, free from all insinuation of empiricism, and, as the article is not expensive, it will no doubt be largely sought after.

## MALPRACTICE SUITS IN FRANCE.

The Paris correspondent of the *British Medical Journal*, for February 7th, gives an account of an interesting suit for malpractice in which an action was brought by an *officier de santé* against M. Trélat, Professor at the Ecole de Médecine, and M. Delens, of the St. Antoine Hospital. M. Bouyer, the plaintiff, stated his case as follows: In the act of nailing down a box in May, 1883, he slightly injured the left forefinger. He sent for M. Pioget, his neighbor. M. Delens and M. Trélat were called in by M. Pioget, and the plaintiff complained that a number of operations were performed on him, and that he was conducted to a *maison de santé*, and that M. Delens applied undiluted alcohol to his bleeding wound; that drainage-tubes were applied, and camphor-dressings bandaged on. After six weeks of daily agony, he left the *maison de santé* with a deformed hand. M. Bouyer accused MM. Delens, Trélat, and Pioget of having treated and tortured him against his will, of having injured him by unskilful treatment, and named his damages at 20,000 francs (\$4,000). M. Pioget declared that the plaintiff had a deep wound in the left forefinger, which required constant care day and night; symptoms of septicæmia soon appeared, and it was necessary to call in surgical assistance; very serious lymphangitis had set in, and several collections of pus had formed. The patient expressed gratitude for the care taken of him, and never opposed any part of the treatment, otherwise his wishes would have been considered. M. Trélat accepted the responsibility of having M. Bouyer removed to a *maison de santé*;

his condition required it; he was in an almost hopeless condition, and could not otherwise have had the necessary attention given him. M. Bcuyer, the plaintiff, was condemned to pay damages of 3,000 francs (\$600), to each of the three defendants. A few such verdicts in Canada would be hailed with delight by the profession, and would most effectually put a stop to much vexatious litigation.

**MEDICAL EXAMINATIONS.**—The following is a list of the successful candidates in the various Universities and Colleges in Canada, so far as we have received returns.

**COLLEGE OF PHYSICIANS AND SURGEONS, ONT.—FINAL**—J. A. Burgess, A. F. Baumann, C. H. Britton, J. D. Courtenay, T. C. Cowan, Margaret A. Corlis, F. W. Cane, H. C. Cunningham, J. A. Couch, F. Campbell, P. E. Doolittle, J. R. Dales, P. A. Dewar, A. W. Dwyer, W. Ewing, D. D. Ellis, D. W. Eberts, J. Ferguson, H. B. Ford, A. Graham, W. J. Gunne, W. S. Harrison, H. J. Hamilton, A. R. Harvie, J. H. Howell, H. H. Hawley, A. R. Hanks, F. Harkin, D. O. R. Jones, J. H. Knight, A. B. Kinsley, C. A. Krick, W. A. Kyle, R. J. Lockhart, W. V. Lynch, A. T. Little, R. Lucy, H. D. Leitch, F. G. Lundy, D. J. Minchin, L. J. Mothersill, J. Marty, W. J. Mitchell, D. C. McLaren, M. C. McGannon, N. McCormack, G. A. Peters, J. J. Paul, W. T. Parry, J. E. Pickard, G. F. Palmer, J. A. Rutherford, H. G. Roberts, Helen E. Reynolds, D. G. Russell, C. F. Snelgrove, J. N. Simmons, A. M. Shaver, S. Scott, J. G. Sutherland, C. E. Stacey, J. A. Stirling, E. A. C. Smith, Wm. Spankie, L. W. Thompson, O. Totten, C. Trow, A. Trudel, J. A. Watson, W. H. Wright, D. J. G. Wishart, E. G. Wood, G. Veitch.

**PRIMARY**—J. V. Anglin, A. F. Baumann, G. M. Brodie, W. C. Beeman, H. E. Burdett, F. Campbell, Margaret A. Corlis, J. Casselman, J. B. Caruthers, C. R. Charteris, W. F. Cale, G. R. Cruikshank, J. F. Campbell, C. R. Cuthbertson, S. S. Cornell, C. Collins, J. M. Conerty, H. E. Drummond, W. G. Dow, W. Dow, M. L. Dixon, D. Dunton, A. A. Dame, A. Ego, J. H. Eastwood, A. B. Eadie, W. Ewing, J. M. Fraser, E. J. Free, W. H. Fox, Ada A. Funnell, J. M. Forster, D. E. Foley, J. W. Fraser, A. W. Gardner, J. Guinane, W. R. Gillespie, H. P. H. Galloway, T. D. Galligan, W. Giles, W. D. Green, W. J. Glassford, M. J. Glass, D. M. Gordon, J. H. Hoover, W. B. Hopkins, Geo. Hunt, J. W. Hart, C. W. Haentschell, F. C. Heath, J. E. Hanna, A. Hotson, J. A. Harvie, J. H. Hamilton, D. Johnston, M. James, M. J. Keane, D. Kester, W. J. Logie, F. G. Lundy, M. J. Mullock, D. E. Mundell, J. C. Moffatt, C. F. Moore, J. Macoun, W. J. Mitchell, J.

C. McCabe, D. C. McLaren, J. C. McAllister, T. McEwen, D. McEdwards, H. A. McCallum, E. McLaughlin, A. F. McVety, J. McLurg, Alice McLaughlin, O. G. Niemeier, W. R. Nichols, T. H. Orton, I. Olmsted, Annie L. Pickering, T. S. Philp, A. B. Riddell, H. G. Roberts, D. Sinclair, E. A. C. Smith, W. Spankie, W. R. Shaw, R. S. Smith, W. O. Stewart, C. R. Staples, J. M. Shaw, H. C. Scadding, D. Storms, J. P. Shaw, J. J. Soden, A. F. Tracey, A. B. Thompson, J. A. Tuck, J. D. Thorburn, A. Trudel, S. West, R. West, W. R. Walters, F. Woodhull, E. J. Watts, R. J. Wilson, E. W. Wright, A. F. Woodward, E. G. Wood, A. E. Yelland.

**TRINITY UNIVERSITY, TORONTO**—M.D., C.M.—J. R. Logan (*Gold Medal*), H. H. Hawley (*Silver Medal*), A. M. Shaver, N. Allan, S. Scott, A. Graham, D. C. Throop, C. E. Stacey, W. V. Lynch, H. D. Leitch, C. F. Snelgrove, A. F. Little, F. Campbell, A. Hanks, P. A. Dewar, F. C. Hood, J. Lindsay (*Honors*). R. J. Lockhart, R. Lucy, J. G. Harper, H. G. Roberts, T. S. Farrar, D. O. R. Jones, C. Trow, A. H. Edmison, J. N. Simmons, P. E. Doolittle, W. J. Gunne, H. W. Hoover, O. Totten, J. J. Paul, J. A. Watson, H. S. Bingham, J. A. Couch, J. Ferguson, W. H. Pepler, A. F. Baumann, L. W. Thompson, A. T. Woodward, F. G. Lundy, H. J. Caldwell, J. Evans, G. Leitch, R. A. Barber, J. G. White, S. A. Metherell (M. B.), G. J. Charlesworth, J. E. Jenner, R. M. Fairchild, H. Hislop, and J. D. Wilson.

**PRIMARY**—J. R. Logan, H. H. Hawley, John McLurg, James McLurg, J. Hamilton, W. R. Nichols, J. M. Thompson, D. McLaughlin, A. E. Yelland, H. Campbell, C. K. Staples, J. E. Midgley, B. Hawke, C. E. Thompson, J. C. Moffatt, D. McEdwards, J. W. Hart, T. S. Philp, T. Primmer, W. F. Graham, W. Panson, M. Maxwell, W. H. Mackay, J. P. Shaw, D. A. Kidd, H. R. McCullough, W. A. Fish, (*Honors*). F. G. Lundy, A. J. Stevenson, W. Giles, H. C. Philips, J. S. Patterson, J. H. Hoover, O. G. Niemeier, F. E. Luke, J. A. Tuck, D. M. Gordon, J. J. Soden, C. A. Toole, D. Thompson, J. C. C. Grasett, S. H. Irwin, D. Kester, H. Blair, J. W. Shillington, T. Wilson, G. Gordon, S. T. Bell, R. A. Barber, J. B. Reid, H. S. Bingham, H. J. Caldwell, J. G. White.

**MCGILL UNIVERSITY, MONTREAL**—M.D., C.M., E. G. Wood, *Holmes Gold Medal*; S. Gustin, *Prizeman*; F. G. Finlay, H. T. Hurdmann, M. C. McGannon, T. A. Baird, J. Elder, D. W. Eberts, *Honors*. R. H. Arthur, J. H. B. Allan, F. N. Burrows, Geo. O. Cassidy, W. S. Daly, D. Corson, J. H. Darey, H. Dazé, W. W. Doherty, F. McD. Harkin, E. O. Hallet, A. E. Hanna, A. C. Hawkins, R. T. Irvine, H. D. Johnson, W. H. Klock, J. W. McMeekin, N. McCormack, H. J. McDonald, D.

L. McMillan, F. H. Powell, G. F. Palmer, A. Robertson, J. L. Shibley, D. G. Wishart, J. A. K. Wilson.

**PRIMARY.**—H. A. Lafleur, *Sutherland Gold Medal*; E. J. Evans, *Prizeman*; J. A. A. Kelly, D. L. Ross, E. H. P. Blackader, R. A. Kennedy, L. F. Ross, T. J. Haythorne, R. C. Kirkpatrick, W. Hall, and J. M. Fraser, *Honors*. P. Aylen, C. W. Boggs, S. W. Boone, A. W. Campbell, L. H. Carter, W. Cattanach, A. MacD. Cowie, D. McG. DeCow, H. Dazé, J. A. Dickson, E. H. Earl, W. E. Ellis, W. D. Ferguson, E. W. Fillmore, J. D. Flagg, A. W. Gardner, W. C. Haentschell, A. L. Hamer, J. W. Johnson, A. C. Leslie, W. F. Loucks, D. D. McDonald, G. A. McMillan, V. H. Morgan, T. J. Norman, L. E. M. Pomeroy, A. Poole, E. Reavely, G. C. Richardson, D. J. Scully, D. Sinclair, G. C. Stephen, P. H. Warneford, E. P. Williams, J. F. Williams, A. A. Young.

**Botany Prize.**—T. A. Clouston. *Practical Anatomy.*—1st year, W. J. Bradley; 2nd year, H. A. Lafleur. *Clinical Medicine.*—H. S. Birkett.

**TRINITY MEDICAL COLLEGE, TORONTO**—*Fellowship Degree.*—H. H. Hawley, *Gold Medal*; J. R. Logan, *1st Silver Medal*, A. M. Shaver, *2nd Silver Medal.*—D. C. Throop, C. F. Snellgrove, S. Scott, A. T. Little, *Honors*. N. Ailan, A. Baumann, H. S. Bingman, J. A. Couch, F. Campbell, H. J. Caldwell, P. E. Doolittle, P. A. Dewar, A. H. Edmison, T. S. Farrar, A. Graham, H. W. Hoover, E. C. Hood, A. R. Hanks, D. O. R. Jones, R. Lucy, H. D. Leitch, W. V. Lynch, J. Lindsay, R. J. Lockhart, J. J. Paul, W. H. Pepler, H. G. Roberts, C. E. Stacey, J. N. Simmons, O. Totten, J. Watson.

**Primary.**—H. H. Hawley, J. Hamilton, J. R. Logan, Jas. McLurg, W. R. Nichols, J. M. Thompson, *Honors*. H. Blair, S. T. Bell, R. H. Barber, H. S. Bingham, T. F. Campbell, H. J. Caldwell, W. A. Fish, W. Giles, W. F. Graham, D. M. Gordon, G. Gordon, J. C. C. Grasett, B. Hawke, J. H. Hoover, J. W. Hart, D. Kester, D. C. Kidd, F. G. Lundy, D. McLaughlin, J. E. Midgely, J. C. Moffatt, D. McEdward, M. MacDowell, H. R. McCullough, O. G. Niemeier, G. S. Paterson, H. C. Phillips, T. S. Philp, T. Primmer, J. B. Reid, J. W. Shillington, C. R. Staples, A. J. Stevenson, J. P. Shaw, J. J. Soden, J. A. Tuck, C. E. Thompson, C. A. Toole, D. S. Thompson, T. Wilson, A. E. Yelland.

**Scholarships.**—First, 1st year's scholarship, G. H. Fere; second, 1st year's scholarship, W. S. Cummings; second year scholarship, John McLurg; third year scholarship, W. H. McKague. Upwards of 80 candidates successfully passed the first year's examination.

**QUEEN'S UNIVERSITY, KINGSTON**—*M. D.*—W. Spankie, B. A., and H. C. Cunningham, equal.

*Gold and Silver Medals.*—T. A. Bertram, C. W. D. Clarke, Mrs. Corlis, H. G. Dawson, A. W. Dwyer, H. B. Ford, E. Hooper, W. A. Kyle, Helen E. Reynolds, H. Ray, D. G. Russell, J. A. Stirling.

**Intermediate Examination.**—T. A. Beeman, H. Burdett, Joseph Casselman, C. Collins, N. Coy, A. A. Dame, Miss A. E. Dickson, M. L. Dixon, F. D. Gilligan, G. C. Jack, A. Jamieson, W. M. Mather, P. J. Mellow, E. J. McArdle, E. McLaughlin, A. F. McVity, Miss M. Oliver, T. B. Smith, D. Storins, E. W. Wright. *Primary and Intermediate.*—F. Bruce, J. M. Conerty, S. Cornell, J. G. Creeggan, B.A.; E. J. Donovan, D. E. Foley, F. C. Heath, B.A.; J. J. Lane, D. E. Mundell, J. Mundell, J. M. Shaw. *Hospital Surgeons.*—M. L. Dixon and D. E. Mundell. *Demonstrators of Anatomy.*—E. W. Wright and J. V. Anglin.

**VICTORIA UNIVERSITY—M.D.C.M.**—J. Barber, A. W. Bigelow, J. A. Burgess, J. R. Dales, J. S. Freebourne, W. A. Goodall, S. M. Hay, A. R. Harvie, L. L. Hooper, H. J. Hamilton, C. J. C. O. Hastings, A. B. Knisley, E. E. King, J. Marty, W. C. McKinnon, H. McGillivray, J. E. Pickard, W. T. Parry, D. Pool, P. P. Park, J. A. Rutherford, J. G. Sutherland, L. G. Smith, W. T. Teasdall, T. Verner, D. M. Williams, H. A. Wright, H. A. Wright, W. H. Wright, G. Simenton.

**Primary.**—G. M. Brodie, D. B. Cruikshank, J. Caven, F. Campbell, E. Campbell, J. A. Carbert, C. R. Charteris, A. E. Collins, C. R. Cuthbertson, W. G. Dow, W. Dow, D. Dunton, W. H. Fox, E. J. Free, W. G. Glasford, P. H. Galloway, W. R. Gillespie, A. O. Hastings, W. B. Hopkins, R. Hillier, G. Hunt, S. J. Jones, J. Leeming, J. M. McCallum, C. F. Moore, T. M. McFaul, C. F. Nairn, J. F. Orr, J. Rea, P. J. Rice, W. R. Shaw, J. C. Smith, W. B. Thistle, A. F. Tracey, J. C. Vrooman, R. J. Wilson, S. West.

**ONTARIO MEDICAL ASSOCIATION.**—We desire to draw special attention to the meeting of the Ontario Association, which will be held in London, Ont., on the 3rd and 4th of June. A number of interesting and valuable papers have been promised and every effort is being made by our brethren in London to make the meeting a success, and from what we know of the Western men, we feel assured that nothing will be left undone that can contribute in any way to make the meeting in every respect a success. It will be remembered that this year a new departure will be inaugurated. Instead of the annual reports on medicine, surgery, and obstetrics, the chairmen of the committees respectively will open the discussion on specified subjects, as follows: Medicine,—Dr. Tye, of

Chatham, Diphtheria ; Surgery,—Dr. Powell, of Edgar, Plaster Splints ; Obstetrics,—Dr. Temple, of Toronto, Intra-Uterine Medication. The usual certificates will be issued by the Secretary entitling members to reduced rates by the different railroad lines. We trust that there will be a full attendance of members.

ONTARIO MEDICAL COUNCIL ELECTIONS.—The elections for representatives to the Ontario Medical Council takes place on the 26th inst. Candidates for the Territorial Divisions must receive the nomination of, at least, *ten* registered practitioners resident in such Division, and forward the same to the Returning Officer for the Division on the 5th of May. Voting papers will be issued by the Registrar on the 12th inst. Among the candidates recently brought forward may be mentioned Dr. Jas. Russell, of Binbrook, for the "Burlington and Home" Division, Dr. McDonald, of Hamilton, having retired. Dr. Russell has received a numerous signed requisition, and his election may be safely counted upon. Dr. Orr, of Maple, has also received a large requisition to become a candidate for the King's and Queen's Division, and intends to contest the seat with the old member, Dr. Allison.

ANÆSTHESIA BY THE MIXED METHOD.—This method of producing anæsthesia has been highly spoken of by many leading surgeons. It consists in the administration of a hypodermic injection of morphine and atropine prior to the inhalation of ether or chloroform. The stage of excitement is very slight, anæsthesia occurs more rapidly and the patient rarely vomits. A large dose of bromide of potassium on the evening and morning before the operation, has been found to bring about similar results, and is worthy of further trial. In a few cases in which we have tried it, the good effect has been very wonderful.

APPOINTMENTS *Re* NORTH-WEST REBELLION.—Dr. Bergin, (M.P.) has been appointed Surgeon-General, and Dr. Roddick, of Montreal, Deputy Surgeon-General ; Hon. Dr. Sullivan, Purveyor-General ; Dr. Orton, M.P., Brigade Surgeon.

HOSPITAL AND AMBULANCE CORPS.—C. M. Douglas, Surgeon-General ; Dr. Bell, of Montreal ; Dr. A. Graveley, of Cornwall, Ont. ; Dr. J. Reddick, of Winchester, Ont. ; Dr. E. Hooper, of

Kingston, Ont. ; Dr. F. H. Powell, of Ottawa, Ont. ; Surgeons. FIELD HOSPITAL, No. 2.—D. H. Casgrain, of Windsor, Ont. ; Surgeon-Major, Dr. R. Tracey, of Belleville, Ont. ; Dr. N. O. Walker, of Toronto, Ont. ; Dr. Francis Murray, of Montreal, Que. ; Dr. Cloutier, of St. Arsene, Que. ; Dr. Phillippe Pelletier, of Quebec ; Surgeons. Dr. Nattress, Surgeon-in-Chief of the Red Cross Corps. Along with these, a staff of medical men, medical students and dressers have gone to the front.

Dr. E. Allen has been appointed Surgeon to the 30th Wellington Battalion of Rifles, and Dr. W. H. Johnson, Assistant Surgeon.

MERCURY AND IRON.—We have seen it stated that iron given with mercury would prevent salivation from the latter. We have tried it many times, giving it in small doses for a long time, without salivating our patients. How much this result depends on the iron given with the mercury we cannot say, but it is a fair presumption that the iron has some effect in preventing the bad effects often accompanying fractional doses of mercury long continued, especially when it is necessary to continue its use for the cure of syphilis.

The *London Medical Times* considers the following the most unfortunate *lapsus calami* which has come under its observation for a long time. The hero of the young lady novelist has succeeded with great difficulty in saving the heroine from falling down the precipitous side of a mountain on which they have lost their way. The heroine has fainted and is apparently lifeless. But to his intense delight the gentleman discovers that the heart still beats "by the pulse in her femoral artery."

DOBELL'S SOLUTION.—The following, which is a very pleasant, soothing, cleansing, and disinfectant wash, is especially recommended in the local treatment of catarrh, laryngitis, &c. :—

R	Acid carbol.	3ss.
	Sod. bicarb,	
	Sod. bibor,	aa. 3j.
	Glycerini,	3j.
	Aquam,	ad. Oj. M.

SIG.—Apply with a nasal syringe or by insufflation.

COMPOUND FERRIC MIXTURE.—The following which is an excellent tonic and hæmatic, is said to

be used in the Charing Cross Hospital, London, Eng. :—

R	Ferri sulph.	grs. xx.
	Potas carb.	grs. xxiv.
	Sachar. alb.	grs. xlviii.
	Aq. cinnam.	ʒiv.
	Aq. puræ.	ad. ʒviii.

SIG.—One to two tablespoonfuls three times a day.

THE DYSPNŒA OF BRIGHT'S DISEASE.—In a paper read before the Canada Medical Association by Dr. Howard, of Montreal (*Can. Med. & Surg. Jour.*), on the varieties of dyspnœa met with in Bright's disease, he illustrated the following points: (1) That marked dyspnœa may occur in Bright's disease not due to gross lesions in the lungs, pleura, or heart, such as inflammation or œdema of the lungs, hydrothorax, or pleurisy with effusion, endoor peri-carditis, or valvular disease. (2) That it may be continuous dyspnœa, or of a paroxysmal character, resembling ordinary spasmodic asthma; and that these types may occur in the same case, although in his experience, the continued variety is more frequent than the asthmatic. (3) That these forms of dyspnœa may occur as the prominent symptoms of renal disease, and their origin may escape recognition if the urine be not carefully examined, as well as the heart and pulse. (4) That Cheyne-Stokes respiration is often a symptom of Bright's disease, and that it obtains in both acute parenchymatous and in chronic interstitial nephritis. (5) That while usually an evidence that the fatal issue is near at hand, it may occur in a chronic form, and may occur for weeks, perhaps even for years. (6) That these several forms of dyspnœa just mentioned are very probably due to that defective renal elimination called uræmia. (7) That in the acute forms of Bright's disease, serious or fatal dyspnœa sometimes, but rarely, occurs in connection with effusion into the submucous membrane of the larynx (œdema glottidis).

#### LOCAL APPLICATION FOR PILES.

R	Pul. opii.	
	" Aloes	aa grs. v.
	Ext. Hamamelis,	ʒj.
	Cosmoline,	ʒj. M.

SIG.—Sponge the parts with warm water and apply after each defecation.

PARALDEHYDE IN DELIRIUM TREMENS.—This new remedy has been found successful in the treatment of delirium tremens, after the failure of potassium bromide, valerian, hyoscyamus and morphine to produce sleep. This agent is claimed to be a hypnotic, producing a perfectly natural sleep of from two to six hours' duration, from which the patient awakens without any sense of distress, headache, dulness or nausea. It may be administered in the form of an elixir, two drachms of the drug being dissolved in an ounce of simple elixir and a tablespoonful administered, to be repeated when necessary.

BRITISH DIPLOMAS.—Drs. Davidson and Furrer, (Trinity), have been admitted to the M.R.C.S., Eng. Dr. W. A. Goodall (Toronto) has obtained the License of the King's and Queen's College of Physicians, Dublin.

We are very much pained to learn of the death of Private Ferguson, son of Dr. R. B. Ferguson, of Winnipeg, in the Fish Creek battle. The Dr. has our deepest sympathies in his severe family affliction.

CORONER.—Dr. J. M. Cotton has been appointed coroner for the County of York, Ont., and Dr. G. Schmidt for the County of Waterloo.

The death of Dr. Jas. L. Little, of New York, is recorded in our American exchanges.

### Notes, Queries and Replies.

To the Editor of the "CANADA LANCET."

SIR.—If your correspondent, who asks for experience regarding the use of picROTOXINE as a remedy for sweating in phthisis, will refer to McKesson & Robbins "Formula Book," he will find some remarks which influenced me in selecting this drug. I have employed it in cases of sweating from various causes and am very much pleased with the result. Yours truly,

J. H. BURNS, M. D.

Toronto, March 31st, 1885.

To the Editor of the CANADA LANCET.

SIR,—The following question was given at the late Council examination: What poison can a woman take to poison her child, without injuring herself, through her milk, and how can you detect

it by *post mortem* examination of child after death?

Will some one please answer in next LANCET?

Yours respectfully,

L. J. MOTHERSILL.

Tuscarora, April 28, 1885.

### Books and Pamphlets.

INSANITY AND ALLIED NEUROSES; PRACTICAL AND CLINICAL, by George H. Savage, M.D., M.R.C.P. Physician and Superintendent of Bethlehem Royal Hospital, &c. Published by Henry Lea's Son & Co., Philadelphia.

The American reproducers of this work have probably long ago learned the fact that a large book is, in the eye of the student of any branch of medicine, a large evil. They have therefore contrived to squeeze into this unpretending little octavo, on fine paper and in clear type, a quantity of most instructive solid matter, which might not inexcusably have been made to fill one of twice the size. Never has it been our good fortune to rise from the perusal of any work on insanity with more thorough gratification than we have realized throughout all its pages. It was our intention to present to the readers of the LANCET some extracts from which they might be enabled to form an anticipative opinion of the real merits of the book; and with this view we made notings of such passages as appeared to us most saliently instructive, but before we had got over half the pages, these markings had become so numerous that we have reluctantly felt constrained to relinquish our purpose.

The book is presented as a "Manual for Practitioners and Students." Every practitioner of medicine is, or ought to be, a student of insanity; therefore it would not have at all derogated from the dignity of the former to have passed them over unnamed. It is sincerely to be hoped that those of ripe knowledge and prolonged observance will not allow themselves to be distanced in the field of alienism by their juniors. A little money devoted to the purchase, and a very little daily time to the study of Dr. Savage's plain and modest treatise, will not fail to prove profitable investments. But whatever may be the appreciation in which it may be held by the general profession, it is sure to be highly valued by the entire body of

alienistic and neuropathic specialists. Every man who has had any lengthened experience in psychiatry, and has loved his work, will feel, in reading Dr. Savage's graphic and succinct description of cases, as if he had been erewhile walking arm in arm with the author, for years, through the wards of his own asylum; and the retired veteran will have displayed before him a living panorama of mental scenes and shadings, which must revive his remembrance of many anxious and many pleasant days in his past life,—scenes and shadings which lapse of years may have begun to enshroud in the gloom of clouded remembrance, but whose reproduction he will contemplate with a kindred gratification to that of the tired pilgrim on his return to his youthful home.

We cannot but commend Dr. Savage's book to every member of the medical profession, and to every student who aspires to the possession of a sound practical knowledge of mental disorders. It is quite probable that if more attention were given to this department of medical science, the public would be relieved from witnessing many of those scenes of professional conflict in courts of law, which are the opprobria of our profession.

THE POPULAR SCIENCE MONTHLY FOR MAY, 1885.  
New York: D. Appleton & Co. Fifty cents a number, \$5 a year.

The first paper, "Our Recent Debts to Vivisection," by William W. Keen, M. D., is a graphic account of the benefits that have been conferred upon humanity during the last quarter of a century, by means of experiments on animals. There is no strained construction in the argument, and the numerous examples given cannot easily be explained away. Dr. Max von Pettenkofer's valuable and timely papers on "Cholera" end in this number, with the fourth of the series, which is mainly devoted to the subject of prevention. "A Scientific View of the Coal Question," by G. Gore; and "Training in Ethical Science," by Mr. H. H. Curtis, are able articles. "The Nervous System and Consciousness," by Professor W. R. Benedict, illustrated, and "Arctic Exploration and its Object," by Dr. Franz Boas, are both good papers in their respective departments. There is also an article by Professor Tyndall, describing the patient labor, the ingenious methods, and the grand results of "Pasteur's Researches in Germ-Life."



**THE EAR, Its Anatomy, Physiology and Diseases,** a Practical Treatise for the use of Medical Students and Practitioners. By Chas. H. Burnett, A.M., M.D., Professor of Otology in the Philadelphia Polyclinic and College for Graduates in Medicine, etc. With 100 illustrations. Second edition, revised and rewritten. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

The above work will be cordially received by the profession, especially those members who have become acquainted with the author through a perusal of the first edition, or in attendance upon his lectures on this subject. His style is clear and concise, and his methods attractive. The work of revision has been carefully done, and much new matter, rendered necessary by the progress of the science, has been added. The author in the outset gives a description of the anatomy of the parts, which is followed up by a description of the instruments used, and how to handle them, and concludes with a clinical history of the various diseases and their appropriate treatment. The work will be found very useful to those desirous of acquiring a knowledge of the diseases of the ear.

**THE SCIENCE AND ART OF SURGERY.** By John Eric Erichsen, F. R. S., LL., D., F. R. C. S., Emeritus Professor of Surgery in University College, etc. Eighth Edition Revised and Edited by M. Beck, M. B., Lond., F. R. C. S., Eng. Prof. of Clinical Surgery in University College, London. With 984 Engravings on Wood. Vol. II. Philadelphia: Lea Bros. & Co. Toronto: Hart & Co.

We have already noticed with comments the first volume of this classic work on surgery, and it only remains at present to notice the issue of the second volume. It embraces a consideration of those affections, not included in the first volume, and contains an appendix on corrosive sublimate as an antiseptic. We cannot speak too highly of this excellent work. It represents the most advanced and settled views in regard to the science of surgery, and will ever be found a faithful guide and conseller in practice.

**KIRKE'S HAND-BOOK OF PHYSIOLOGY.** By W. Morratt Baker, F. R. C. S. Lecturer on Physiology at St. Bartholomew's Hospital; and Vincent D. Harris, M. D., London, Demonstrator of Physiology at St. Bartholomew's Hospital. Eleventh edition with nearly 500 illustrations. Vols. I. and II. New York: Wm. Wood & Co.

The above work constitutes the February and

March Nos., of Wood's Library of Standard Medical Authors, and will no doubt be hailed with satisfaction by the subscribers to this "Library." Kirke's Physiology is so well known to the profession that an extended notice would be quite superfluous; the fact that it has reached the eleventh volume speaks for itself. All the recent advances in the science have been incorporated in the work so as to bring it fully abreast of the times.

**AN INTRODUCTION TO PATHOLOGY AND MORBID ANATOMY.** By T. Henry Greene, M.D., Lond., F. R. C. P., Lecturer on Pathology at Charing Cross Medical School. Fifth American and sixth revised and enlarged English edition, with one hundred and fifty engravings. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

This able and instructive work is well known to the profession, and the edition before us fairly represents the status of this important branch of medical study. It is a lamentable fact that too little attention is paid to pathology and its sister science physiology by the majority of medical practitioners on this side of the Atlantic. A careful perusal of such a work as this, however, cannot fail to arouse an interest in the study of this much-neglected branch of medical science.

**BERLIN AS A MEDICAL CENTRE,** by H. R. Bigelow, M.D., Washington, D.C.

The above work will be issued by the New England Publishing Co., Sandy Hook, Conn., during the month of May. It will be a complete and accurate medical guide to Berlin, giving instructions in reference to board, clinics, lectures, expenses, etc., and all information that will be necessary for the medical student abroad. The price will be \$2.

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### Births, Marriages and Deaths.

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On the 15th ult., J. T. Small, M.D., M.R.C.S. Eng., of Toronto, aged 63 years.

On the 29th March, D. A. Livingstone, M.D., of St. Chrysostome, Que., aged 30 years.

On the 10th ult., J. McCurdy, M.D., of Chatham, N.B., aged 42 years.

On the 11th ult., D. Burnet, M.D., of Cobourg, aged 40 years.

On the 23rd March Dr. Thomas Tanner, M.D., of Holstein Ont., aged 64 years.

# THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

VOL. XVII. TORONTO, JUNE, 1885. No. 10.

## Original Communications.

### ON THE BROMIDES IN EPILEPSY.

BY PROF. G. LEE, HOTEL DIEU (*Revista Argentina*).

Translated from the Spanish by J. Workman, M.D.,  
Toronto.

What part of the therapeutic action belongs to the potassium, and what to the bromine? The action of the bromide of potassium on the organism has passed through strange vicissitudes. In the outset all the effects were ascribed to the potassa; after the labors of Traube the effects of the potassic salts became known, particularly of the nitrate on the heart, which, after a short period of excitement, suffered a certain degree of depression, with diminished blood pressure; and it was hence concluded that all the salts of potass, whatever might be the acid or the metalloid, possess true therapeutic properties; but experience soon showed the complete inertia of the chloride, the nitrate and the iodide of potassium in the treatment of epilepsy; it was then proved that potass in general, in whatever dose or combination, did not possess the least therapeutic influence over epilepsy.

This was the second phase of the bromide, diametrically opposite to the first. It is necessary to divide and separate the physiological action into two parts; on the one side, to discover its effects on the brain, the medulla and the skin, which represents its special nature; and, on the other side, its effects on the circulation, the respiration and the temperature, which would be those of its common or alkaline nature.

Here now we have the potass pretty well demonetised; but the physiologist limits himself to a few hours of observation on some animal whose intelligence he cannot penetrate, whilst the clinicist sees and follows the cerebro-spinal phenomena for a long time, and does not hesitate to recognize

the pre-eminence of clinical medicine; it is this which teaches the therapeutic properties, and above all the cerebral action, of the bromides in general, and of the bromide of potassium in particular.

The latest investigations by Kroy, on man, show clearly that all the virtue resides in the bromine; yet, on the contrary, on animals, the excessive proportion of 67 per cent. of bromine against 33 of potass in the bromide passes, or may pass, through without producing the least effect.

The third vicissitude undergone by the bromide of potassium, not only despoiled it of its curative property, but transformed its action on the heart into a real intoxication of the organ; in this turn the disadvantages of bromism were imputed to the potass, which was regarded as decidedly lethal; and it was believed that it was merely necessary to replace it by some other alkaline base, in order to get clear of all the dangers of a drug which is prescribed through months and years. This gave birth to the bromide of sodium, the bromide of ammonium, and lastly to the mixture of these two with the inevitable bromide of potassium. The polybromides, perhaps for the very reason that their complex effects are unknown, are to-day much employed, as a consequence of the potassophobia; yet it is enough to know that the habitual dose of six grams of the bromide of potassium introduces into the system only two grams of potass. How has it happened that such a dose, taken into the stomach, has never produced the least inconvenience?

The ashes of alimentive vegetables represent 3 to 4 % of their entire mass; the mineral residues of the potato contain 60 % of potass, that is to say, more than a grain and a half for every 100 grams of the tuber, and yet neither its sedative virtue, nor the danger of its use, has ever been suspected. Lastly, it is easy to prove that in order to obtain the equivalent effects of 5 grams of the bromide of potassium, the dose of the bromide of sodium must be raised to 10 or 15 grams. So, in order to avoid a very uncertain danger, we inevitably, by this excessive dose of the bromine, fall into the grave inconveniences of bromism, as is proved by the convulsions caused by injections of the bromide of sodium, just as by those of the bromide of potassium, into the blood of animals. Rochefonte has demonstrated this by his investigations in my laboratory. The bromide of am-

monium is still more exciting, so that the three united salts do not present any advantage over the potassic bromide, which figures for one-third in the mixture styled the polybromide.

*Absorption and Dose—Effects of the Bromide on the Eliminant Organs—Slight Bromism of the Respiratory Mucous Membrane, and of the Skin.*

The bromide is readily and promptly absorbed by all the mucous membranes; after some minutes it appears in the urine, and is eliminated almost in totality in two or three days; hence the imperious necessity of continuing the treatment without interruption; at the most it may be suspended for a day at a certain time, or the dose may be decreased; but to suppress it is dangerous. I have seen patients who, from having neglected the use of the medicine for a few days, have been attacked with convulsive fits after a quietude of eight months or a year.

The bromide is eliminated by the kidneys in great part, very little by the salivary glands, and still less by the stomach; and these organs are, as we shall show, but little impressed by it. The same fact does not apply to the respiratory mucous linings, which also serve as a means of passage to the bromide; they are profoundly altered in its elimination. The pharyngeal mucous membrane becomes the seat of a pricking, painful sensation, and of a well-pronounced paleness, due to the local ischæmia; after the doses have been raised to five or six grams, the velum palati is anæsthetised more or less completely. Voisin, who has closely studied the effects of the bromide, advises that it be taken to the extent of 10 or 12 grams, that is to the production of insensibility of the isthmus of the fauces, which would be the sign of saturation; but there are such individual differences in this respect that we should run the risk of poisoning the patient before this indication of brominal impregnation might appear, which is, so to say, *en passant*, perfectly useless. Voillez has spoken of directly anæsthetising the fauces with gargles strongly bromidised, with the view of restraining the cough as well as the vomitings that follow the kinks in whooping-cough and phthisis; this mode of extinguishing the impressions of sensibility, which provoke the reflex acts of coughing, has had no good result; it is, in fact, very difficult to prolong the contact of the bromide

with the pharyngeal wall until we effect the loss of sensibility of the mucous membrane. The bromide does not act until after the gastric absorption, and the commencement of elimination of the bromide by the mucous membranes. For the same reasons we do not obtain, unless with difficulty, insensibility of the mucous membrane of the larynx from the mere action of bromidal sprays; in order to extinguish the sensibility of the larynx, as well as of the pharynx, it is necessary to imitate the process of Voisin, and saturate the patient; but to push to this extremity is very dangerous.

The bronchii are frequently the seat of a sharp irritation, which results precisely from the elimination of the bromide by the secretory glands, when it is presented as well as in the bronchial mucosa, in saturated epileptus; this bromic bronchitis, which is introduced by a short, irresistible cough, dry at first, and followed by a slight expectoration, is one of the most grave obstacles to the continuous treatment which epilepsy demands; I had believed it well to quiet this cough, which occurs chiefly in the night, by conjoining atropia with the morphia, but the result of the combination was generally harmful: either the cough did not cease, and it became necessary to interrupt the treatment, and even in three of the most grave cases to give up all medication; or, though the narcotics succeeded in calming the cough, yet they nullified the effects of the bromide; it appeared to me, however, that the tincture of the root of aconite, in doses of one grain per day, presented some advantages over the other narcotics, and above all over the expectorants (such as antimony, sulphur, turpentine), which only aggravate the evil. What, then, after these facts, which are so easily proved, are we to think of the prescription, in obedience to certain precepts, of the bromide in bronchial irritations?

I do not know of any sort of cough, whether of whooping-cough, of hysteria, or still less of tuberculosis, in which relief is derived from the bromide; the very contrary is the result. It must be stated that these prejudicial effects are observed even with the moderate doses of three grams; I have seen a young epileptic girl who could never exceed the dose of a gram and a half. What, then, would have been the result of large doses? In studying the grave bromism we shall find pulmonary inflammations resulting from the abuse of

bromine ; I could cite three unfortunate and convincing examples.

In the skin, as in the bronchii, both a slight and a grave bromism are produced. It is very rare that the bromide, which is eliminated by the integument during life, or, in fatal cases, is found in the sudoriferous glands and likewise in the sebaceous follicles, does not, from the first day, produce a very evident effect on both layers of the skin ; even from the first day, in small doses, it produces acnes, which are seated preferentially on the face or the breasts ; two or three grams suffice to bring this eruption, and it may be generalised and become numerous, so as to prevent the continuation of the treatment. In these cases I have always employed, with good results, arsenic in addition to the bromide ; of late it has been proposed to use the bromide of arsenic, but it offers no advantage over the bromide of potass., with the addition of 10 or 12 drops daily of the solution of Fowler.

The kidneys are not changed either in structure or function in the elimination of the bromide ; they do not secrete a larger quantity of urine than they do in the normal state, consequently the bromide cannot be regarded as a diuretic. Neither does the bromide change the composition of the urine ; we merely know that it contains more chloride of potass, which leads to the supposition that the bromine leaves its base and that it joins with the sodium in the blood, forming the bromide of this substance ; this would be another proof that it is the bromine alone which acts, whatever may be the alkaline base ; we shall see presently whether it acts on the oxidations, and consequently on the quantity of uric acid and urea eliminated in the urine.

The salivary glands eliminate the bromide with less facility than they do the iodide, but if the dose be increased a notable quantity is found mixed in the saliva ; at the same time there is manifested, without doubt from the reflex action produced by the bromine on the maxillary nerves, a salivation which is frequently abundant and dangerous, and contributes not a little to the enfeeblement of the patients.

The gastro-intestinal mucous lining seems to be but little impressed by the bromide ; it causes gastric pains at the moment of its introduction into the stomach, but these may be avoided or calmed by diluting the salt with a sufficient quan-

tity of water ; the majority of patients, especially if they take the medicine in solution in their aliments, experience no change in the gastro-intestinal functions, nor any painful sensation, dyspepsia or constipation. This functional immunity leads us to suppose that the medicine is not eliminated by the digestive mucous linings, as iodine is. The secretory organs most briskly attacked are, as is seen, the respiratory mucous membrane, on the one part, and the integument on the other. This is what constitutes the first degree of bromism, as indicated by Huchard.

*The Bromide is a Vaso-Constrictor-Medicament, that is to say, an Anemiant.*

After having shown the bromine as acting solely by reason of its two constituent elements, and having pointed out the first degree of bromism of the skin and the bronchii, we now come to define the true and useful properties of the bromide. The principal are two ; one proceeds from the vaso-constrictor effects, that is to say, from its anemiant action ; the other consists in its depressing action over the general reflex power, and more still over the excitability of the general cortex (? cerebral).

The faculty possessed by certain energetic medicines, of acting on the vessels through the intervention of the vaso-motor-centre, has long been established ; some provoke contractions of the vascular muscles ; such are the bromide of potassium and the ergot of rye ; others cause active dilatation of the arterioles, as we showed, conjointly with Meuriot, 20 years ago ; others paralyze the vascular tunics, as the nitrates of amyl and soda ; with the last named we may include curare. It is very remarkable that these medicaments are precisely those which have been prized in the treatments of epilepsy, and often for curious reasons ; for example, the bromide to combat the genital excitation ; belladonna to diminish the spasms ; curare to provoke a curative fever, and the nitrates as energetic and rapid sedatives. In reality, if we abandon the false data of empiricism, and seek for the scientific solution of this complex problem, therapeutics and experimentation fall into accord, and we easily comprehend how so important a role is acted by these vascular-medicaments, and why they deserve to be taken into consideration, despite their qualities, most diametrically opposite from the point of view of their vaso-motor action.

The bromide is undoubtedly an anemiant; Sakokoski, Samola, Sezutzki and all the experimenters are unanimous on this point. By exciting, in the vaso-motor centre the constrictor nerves, the field of the circulation becomes restricted, particularly that of the bulb and the encephalon; it is known that anemia of the medulla oblongata is an experimental character of epilepsy. How are we to reconcile with this fact the beneficial action of the bromide? The reply is easy. The epileptic fit begins with anemia, resulting from the excitation of the vaso-constrictor nerves; against this transitory phase the bromide is powerless, but the fit continues and it ends in a hyperæmic process which provokes vaso-dilatation. It is by its antagonistic and vaso-constrictor action that the efficacy of the bromide is explained; but this is not all: it possesses, as we shall show, a strongly depressive power, or as we might say, a destructive one, over the reflex excitability, alike over the brain cortex and the bulb; consequently it impedes the attack and may also restrain the evolution of the disease.

Well now, is there a single vascular medicament that can be compared to it? Not one. The ergot of rye, which is a vaso-constrictor, visibly excites the reflex power of the medulla; belladonna, which is a vaso-dilator, excites the reflex excitability; as to curare it meets no requirement whatever, by paralyzing the vessels it operates lethally; as to the nitrites of amyl and soda, they have but an ephemeral effect on the fit and the vertigo, and they are, so to say, impracticable because of their toxic action. It now remains for us only to prove the depressing property of the bromide on the excito-motor system.

*The Bromide Represses the Exaggerated Excito-motility in Epilepsy.*

Hurette and Rames, in 1850, recognized in the bromide the anti-excito-motor property which readily explains the insensibility of the pharyngolaryngeal mucous lining, under the influence of large doses. Laborde has studied this special faculty, which acts also on the genital innervations. Since my first investigations in 1858, when my attention as well as that of Brown-Sequard, was given to the hypnotic, or better to say the sedative effects, which in no respect resemble narcotism, and consist above all in a diminution of the impressionability by external influ-

ences, the bromide, taken to the extent of three or four grams nightly, has procured the most tranquil sleep, leaving no vestige of heaviness or pain in the head, such as follow the action of opium. I have utilised this sedative potency of the bromides from the outset of the megrim, which aborts, or is in a certain way shortened.

All these clinical facts ought to leave not the least doubt; an experimentation of late by Albestoni, lauds a physiological proof that seems to me irrefutable, and applies marvellously to epilepsies of cortical origin. By electrising the cerebral cortex, after laying it bear with the trephine, Albestoni produced partial, and often general convulsions; when he previously administered to the animal under experiment two or three grams of the bromide, the electro-excitability of the cortex diminished considerably, and so much the more the longer the action of the bromide was kept up. The medicine, in a certain dose, impedes the electricity in producing convulsions; it appears that resistances are formed in the bromidised encephalon, or this propagation of the excitation to the psycho-motor-centres is prevented. There is then produced a true excito-motor-paralysis, which is all the more curious as the voluntary movements continue unaffected. In proportion to the suppression of the bromide, this state of the encephalon disappears; it recovers its prior excitability, and the electric excitations acquire their convulsive potency.

It is impossible, in this ingenious experiment, to ignore the proof of the depressing power of the bromide over the excitability of the brain. In comparison, Albertoni met with nothing analagous in belladonna or atropia, nor in curare; all these poisons increased or exaggerated the reflex sensibility; nothing further then is to be expected. The bromide is the unique vascular medicine, and at the same time a real anti-excito-motor.

*Grave Bromism.*

It now remains for us to point out the inconveniences, frequently the dangers, of an intense and continued bromidation.

When it is prescribed without the precautions we have indicated, permanently in six grams or more, the patient is exposed to grave alterations in the skin, the mucous membranes—principally the respiratory—failure in the heart's action and

the circulation, and general depression of the encephalic system. I thus summarize the grave bromism: The mouth acquires a foul odor, the gums become pale, and an incorrigible salivation is established, which rapidly saps the powers of the patient. The heart acts slowly and weakly; in doses of 15 grams daily its beats are reduced to half the normal number; by prolonging the administration of these doses, the intra-cardiac nerves and the cardiac muscle itself, may suffer a commencement of paralyzation. At the same time the intravascular pressure is weakened, and the temperature may descend. What is still more grave is the deterioration, or general impairment, produced by a well-marked elimination of phosphoric acid and urea. The peripheral circulation feels this loss of the general forces and of that of the heart; the patient acquires an extreme paleness, with brownish tints, or the extremities even assume a livid hue, which indicates sanguineous extases. The respiration is, in its turn, attacked; besides the cough and the bromidic bronchitis, which are frequent and often severe, I have seen a mortal pneumonia, which I attributed to the bromide, three times produced; one of these cases was followed up by my colleague and friend Peter; it was that of a girl, with deformity of the cranium, who was attacked by epilepsy; the second case was also of a girl who was an idiot; she died of pneumonia with grave alterations of the skin; the third patient was a boy of four years, who took five grams of the bromide prescribed by a physician who treated him by correspondence.

It is, finally, necessary to signalize that excessive debility which amounts even to impossibility to walk, and to hold the trunk erect, a sort of drunkenness, with general insensibility, somnolence, expression of horror, depression of memory, involuntary emission of urine. As soon as any of these manifestations are presented, all treatment should be suspended for a longer or shorter time, and the doses that have provoked the bromism in the skin, the respiratory or the nervous system, must not be renewed.

#### *Physiological Rules of Bromidation.*

It is not enough that we prescribe the bromide even in regular moderate doses, sufficient to obtain a favorable, and above all a definitive, result; it is important to observe all the rules taught by

physiology, for the diminution of reflex excitability. I described these in 1868; they may be found clearly formulated in those valuable annotations which my friend and co-worker, Labadie-Lagrave, has added to the book of Hammond, of which they constitute the complement, and are at the same time an indispensable commentary. I quote textually thus: "The efficacy of the bromide depends almost exclusively on the depressing action which it exhibits over the reflex power of the medulla oblongata and spinalis. Everything that may counterbalance this action, everything that may awaken the morbid excitability of the nervous centres, must be severely proscribed. Epileptics must be forbidden alcoholic drinks, wine, beer, or gaseous waters; alcohol and carbolic acid singularly arouse the faculties of the excito-motor and bulbo-medullary systems. Coffee and tea usually have the same result. The patients must abstain from smoking; the nicotine, by exaggerating (?) the vascular action of the bromide, and in a certain way tetanising the arterioles of the nervous centres, seems to extinguish the useful effects of the bromide. Violent gymnastics, the various hydropathic practices, particularly sea baths and douches, have a very fatal action, by provoking return of the fits. The same result follows physical pains, moral emotions, and genescic excitations."

I forbid all active medication, such as purgatives, emetics, revulsives, cauteries, etc., which are capable of producing a great disturbance of the organism; with still greater reason is it necessary strongly to prohibit abstractions of blood.

#### *Auxiliary Means.*

The auxiliary means which I have been enabled to approve of, are iron, especially the tartrate of potass and iron, one gram daily; arsenic under the form of Fowler's solution, 12 drops daily; quinia in extract and the sulphate of quinine; lastly, cod liver oil, and above all oxygenation by permanent residence in the country; such are the strengthening medicaments destined to combat the dangers of bromism and the weakening of the nervous system.

Bodily exercise in the open air, without fatigue, moderate intellectual work, well directed, constitute the most important auxiliaries—let these be attended to above all in controlling the education

of children; the due functioning of the brain hinders it from atrophying. It is to be kept in mind that functional debilitation of the brain leads to exaltation of the medullo-bulbar system, and therefore tends to exaggeration of the excitomotor power, that is to say, to the return of the epileptic fits.

The bromide, in medium doses of five to six grams, rather exalts than depresses the intellectual powers, which are generally intact between the fits, often indeed much developed, as I have seen in numerous examples; history records great geniuses of this class, as Cæsar, Mahomet and Petrarch, who were epileptics.

*General Results of Bromidation in the Various Epilepsies, and their Principal Manifestations.*

1st. Of 150 epileptics treated by me in 25 years, 90 of whom have been closely observed, during two years and over, the majority began the treatment in ages between 10 years and 30; the commencement of the disease dated back to various epochs; among those who had not reached ten, or who had passed 30, I cite the following: a boy of two years, who had never been able to take more than 25 centigrams of bromide per day, without falling into a profound prostration; he remained without treatment during four years; afterwards he took the bromide, and the fits disappeared. In an analogous case, in a boy of three years, the dose of a gram daily continued for two years, brought about, after some periods of physical depression, a complete cure, and he has continued free for many years. Amongst those over 30 years old, I mention one patient of 52 years, whose mother was an epileptic; his attacks had lasted over 20 years; he marvellously recovered, and his children are exempt from the disease.

2nd. Among these 150 epileptics, I count 10 cases due to deformity of the cranium with idiocy; not one of these was cured; three died after some alternations of relief; death in two of the three was due to bromidic pneumonia, and in the third to ulcerations of the skin, with cachexia. In the remaining 140 cases, I have noted three of vertigo without fits; in one of these the disease has resisted all treatment; it was that of a well-formed girl, very intelligent, who had 40 vertigoes daily; all the means employed were useless; the bad result of the bromide is explicable by the cir-

cumstance that it is much less operative in cortical than in vaso-motor epilepsy. (?)

3rd. All the rest of the patients had convulsive seizures, some of which were preceded by asthma (*asma*, ? *aura*). In the great majority, whatever had been the previous number of the attacks, the disease was ameliorated in this way: the crises disappeared, not to return, unless rarely and far apart, and always so attenuated that the patients did not fall, nor lose consciousness, or have convulsions. Two-thirds of the patients in this category were followed and observed for years; 12 recovered completely, and were able to leave off all treatment. All those who did not recover had suffered the effects of bromism up to the point of being forced to give up the treatment, for a certain time at least; three young girls and a boy of four years had bromic disturbances of the bronchii, so persistent that I was obliged to renounce the bromide, or arrest its effects with aconite. In five other instances I had to contend with bromism of the skin, which became the seat of general eruptions that were often confluent; here the addition of arsenic almost always succeeded in removing this complication. When these difficulties were surmounted, I had nothing to fear, unless errors of hygiene, regimen and drink; unseasonable or too long bathing, and above all hydrotherapy, which hardly ever failed to produce disastrous effects.

4th. The effects of the treatment on the brain have been almost always favorable. Bennett, who has published a series of statistics in this relation, proves the perfect maintenance of the general and the intellectual powers in at least three-fourths of the cases submitted to bromidation, throughout five years. When the intellect becomes weak, the fact is always attributed to the treatment; it is easier and less humiliating to the relatives to fall upon this alternative than to admit the real cause, which is the disease, invading and degrading the brain as it progresses.

In fine, the majority of the organs remain intact; their functioning continues normal, and bromidation, well directed, with observance of the precautions indicated, may produce a definitive cure.

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Luton of Rheims, and Verneuil of Paris recommend strychnia in hepatic affections of alcoholic origin.—*L'Union Médicale*.



## REPORT ON SURGERY\*

BY W. BURT, M.D., PARIS, ONT.

### NERVE-STRETCHING.

The following summary, gleaned from the "Bradshawe" lecture, delivered by John Marshall in December last, gives us the principal information now in our possession in reference to this recent operation. In the operation of nerve-stretching there is a palpable stretching. Nerves nearer to the spinal cord are rather more extensible than those at a distance. This may be owing to the relatively less thickness of the sheath. The distant nerves are smaller, but they are probably better protected. The nerves of the upper limb are more extensible than those of the lower limb, probably for the same reason that the nerves of the lower limb are better protected by sheaths; for we must recognize that it is the sheath that bears the strain when we pull upon a nerve. After a nerve is stretched it recoils. One observer states that after stretching a nerve it recoiled one-fortieth of its length. The safe therapeutic weight varies from about 1 lb. up to 30 lbs. The former, for the smaller nerves, as the mental, the latter for the great sciatic. When nerves are stretched, the epineurium and perineurium lose their wavy appearances and become straightened; the natural segmentation of the medullary sheath gives way to an irregular breaking up. Sometimes the tubuli break, and still more rarely the axis cylinder gives way. After this the nerve degenerates, and after the whole mass of nerve has become disintegrated, restorative changes follow and its function is gradually restored. Sensation and motion are the first to be extinguished, and lastly reflex action.

*Effects on the Cord.*—Practically there is no stretching mechanical effect propagated through the roots of the nerves to the spinal cord. In the sciatic, the stretching effect passes to the sciatic plexus, passes to the roots of the nerves, where it must disturb the spinal ganglia on the posterior roots and it must disturb the dura mater. It may by disturbing the dura mater shake the cord a little through the ligamentum denticulatum on either side, but we find no change of tension in the intra-spinal or intra-meningeal part of the nerve, and no movement in the cord. The effects are

bilateral. The effect of stretching nerves on one side passes over in various degrees to the other side of the nervous system.

*Therapeutics.*—Specially successful in peripheral paralysis and neuralgias of all kinds; less so in tetanus; still less so in epilepsy and tabes. In the case of neuralgias, the presence of nervi nervorum is assumed, and that it is through the rupture of these that the pain is got rid of. Nerve-stretching is said to act, not only by rupturing the assumed nervi nervorum, but in other cases by partially numbing or paralyzing the internal tubules, arresting their function for a time, or, further, by indirect effects on nerve centres. In tabes and central neuralgias it is said to act by producing some indirect effect upon central nerve elements through trophic changes, probably induced by the disturbance of vasi-motor action.

The operation is performed, with one exception, by exposing the nerve, lifting it with the thumb and finger until a *palpable* stretching is produced. Sufficient force is to be used until the nerve sensibly yields to your traction—until you feel an internal creeping movement in the particles of the nerve, of the sheath, no doubt; until you feel a certain attrition and vibration going on—and you must educate yourself to that, and then you will be safe. The thumb and finger can stretch with a force equal to a weight of 30 lbs., the amount said to be sufficient for the largest diseased nerve, the sciatic. Stretch both ways for neuralgia. It is of less consequence to stretch from the extremities in tabes; it is essential to stretch from the trunk or body. A continued even force, firm and resolute, is desirable. Without cutting, Sayre reports, a positive improvement in tabes in thirteen out of fifteen cases, from the use of his suspensory apparatus, for ten minutes three times a week, the sciatic can be well stretched by forced flexion of the lower limb. It appears from the above that the cutting operation should not be resorted to for tabes. The dangers are those of chloroform, thrombus, pyæmia, and disease of the spinal cord, set up by the operation.

### NEUROTOMY.

To the above collection of material in reference to nerve-stretching, I might add the result of neurotomy in a recent fatal case of traumatic tetanus. Patient had the last phalanx of the left

\*Read before the Ontario Medical Association.

ring-finger crushed, splitting the bone into lateral halves. As much of the phalanx was removed as was thought would insure ready healing. When the finger was about healed he complained of not feeling well, but kept at work. On the second day of illness, found jaws closed and spasms coming on, causing him to rest on his abdomen and chest. On the third day. temp. 102; neurotomy of the ulnar, median and radial nerves was performed, completely isolating the finger. The joint was removed at the same time. Chloral and potass bromide were used. By evening the mouth could be opened with the greatest freedom, and only during the spasms would it shut violently. The spasms, however, continued; the temperature gradually rose, and on the third day after the operation death ensued. The only direct effect of the operation, in this case, was the relaxation of the muscles of the jaw. The reason of the delay in operating in this case, was the almost total absence of the spasms for a time, under the use of the chloral and bromide mixture. They however returned violently, although the medicine was kept up with the result above stated. There appears no doubt that it is through the medium of the nervous system that the blood changes if any are induced. I have no doubt, however, that the pathological changes take place first in the nervous system, whether the disease be idiopathic or traumatic.

#### ACCIDENTS OF GAMES.

*Foot ball.*—I will simply quote a few paragraphs that should prevent a Canadian adopting the rude and barbarous sport of the United Empire. I refer to the Rugby game. What is said by surgeons in England against foot ball, is aimed chiefly at the Rugby rules. If these rules are entirely done away with, or even modified, I believe it will be because of their unanimous condemnation by the profession. Surely unavoidable accidents happen only too frequently without playing according to rules, the inherent nature of which will lead to serious injuries. A. Williamson, manager of the Northern Accident Insurance Co., states in the *Lancet*, "that he had been compelled to decline renewing all special policies covering foot ball and bicycling accidents only, as our experience went to show that these risks, as a special class, were most unprofitable." The accidents attending other sports cannot be numerous or dangerous, for he states, "all our

general accident policies cover these risks (foot ball and bicycling) without extra premium." The *Lancet* states that our often repeated assertion that accidents arising from foot ball, as at present played, are more numerous than those occasioned by any other athletic exercise. One of the most painful features of foot ball is the fact that so many of the injuries received in playing this game, when not immediately fatal, often incapacitate the player for life, and render him a burden on his relatives. Such phrases as the following appear in the English medical periodicals, referring to the Rugby game: "The uncontrollable brutalities and roughness of the pastime."—"Brutal and dangerous." Without doubt the consensus of opinion of surgeons is that no such game as the Rugby should ever be indulged in. Under modified rules accidents happen only too frequently. During two seasons of short duration your reporter observed in the matches he played in, a broken clavicle, a dislocated elbow, a fractured pelvis, a case of temporary unconsciousness, besides many minor injuries, chiefly bruises to the shins and ankles. Even this much happened under rules which did not permit the carrying of the ball. From the medical literature on the subject, it appears that those who would approve of the Rugby game, and who see in it many qualities, would approve likewise of a bull or cock fight. The chief danger of the Rugby game appears to be affections of the spine, resulting in muscular paralysis.

*Cricket.*—This pastime is not altogether free from accidents, but I think it may be asserted that if the crease is a good one the accidents will be few. The players who receive most bruises are the wicket-keeper and the batsman. If played, however, according to custom and rules, bruises are very rare. In the past two years while on the cricket field, I noticed a fracture of the zygomatic arch, in a wicket-keeper, and a fracture of the nasal bones in a batsman. Both of these accidents were due, it is altogether likely, to an imperfect crease. No game it appears could be more free from accidents, although it is not uncommon to see a wicket-keeper or a batsman lay sprawling on the ground from the ball occasionally striking the testicle, but the injured one soon recovers and proceeds with the game. Accidents of a more serious nature are very seldom reported from the cricket field.

*Lacrosse.*—Accidents in this game occur undoubtedly, in proportion to the manliness of the

players, whether they play with the ball or play at each other. It will rest mainly with the umpire if accidents are numerous. It is in their power to prevent them. Many a scalp wound and bruise has occurred unnecessarily; but neither in lacrosse nor in cricket is there any special injury which has taken the name of the sport.

*Lawn Tennis.*—It is to lawn tennis that we look for special accidents that have taken the name of the game.

1st. We have lawn tennis arm, a rupture of the pronator radii teres, produced by the back stroke.

2nd. Lawn tennis leg, a rupture of the plantaris, the symptoms of which are quite marked and uniform.

3rd. Lawn tennis knee. This last consists in nearly every conceivable sprain or bruise of the ligaments and cartilages of the knee-joint.

I shall not refer to the various motions which produce these injuries, but will simply state that it is well to know that these injuries are inherent in the game of lawn tennis, which has now become so fashionable. An intelligent knowledge of these minor accidents, as it were, are not beneath the careful study of the surgeon. And here I cannot help referring you to an exceedingly clear report of a case of lawn tennis leg, by Dr. Powell, of Ottawa, in the *London Lancet*, of July 7th, 1883.

*Bicycle.*—As to the bicycle accidents, although their name is legion, there is none which have the name of the game. It is simply alleged that varicose veins of the lower limbs, as well as varicocele, may be caused by it, and that hernia inguinal, if not produced, is at least aggravated by it, but the evidence is as yet conflicting.

*Base-Ball.*—Accidents from this sport are divided chiefly between the pitcher and catcher. A few years ago I observed, in a pitcher, a swelling and tenderness in the region of the attachment of the biceps to the head of the fibula, no doubt due to a sprain of the muscle. The pitcher's movements are such that it is altogether likely this injury may result from it. On advising him to abstain altogether, he got well, but before doing so the trouble was aggravated at every attempt. He can now, however, ride the bicycle without any return of the affection whatever.

The above is simply an imperfect glance at the accidents in connection with the out-door sports which are so much indulged in.

#### GUNSHOT WOUNDS.

And here I wish to quote from a lecture delivered by Sir Wm. MacCormac, of St. Thomas' Hospital, London. He states: "That there is infinitely more danger created by the surgeon who attempts to search for and extract a bullet, than would result from leaving half a dozen bullets to take care of themselves." This has not been my own experience in reference to pistol-shot wounds. I shall refer to only one example. A patient came under my observation, who accidentally shot himself in the wrist. He was kept under ether some three hours, it was alleged, but the bullet was not discovered. Considerable inflammation in and about the wrist, with stiffening and a contracted hand following, which only yielded after prolonged treatment. This may have happened without the prolonged search, but with my present knowledge of the subject if the bullet required a search in order to find out its locality, the search should not be made." Further on he states in regard to gunshot wounds of the abdomen: "Some months ago Marion Sims published, in one of the medical journals, an interesting series of papers in which he said that these injuries should not be left to themselves; but what he proposed was that the abdominal cavity should be opened and searched, the bullet be found and extracted, the peritoneal cavity then be cleansed antiseptically and closed, after which treatment it might be possible for recovery to follow, when death was otherwise almost inevitable." Such it appears has been the action taken in reference to gunshot wounds, which has been attended with the best results. But the change is not general yet, and it is to draw attention to this important subject that the above short report of gunshot wounds is made.

#### MEDICAL NOTES FROM THE NORTH WEST FIELD FORCE.

BY G. STERLING RYERSON, M.D.C.M., L.R.C.S., ED.  
Acting Surgeon, Royal Grenadiers.

It speaks well for the constitutional stamina of the regiment to which I belong and also for the field force generally, to be able to report that there is no serious illness among either officers or men. Diarrhœa has been somewhat prevalent, owing largely to the alkaline character of the water, which only was obtainable. There have been a few cases

of dysentery also. Coughs and colds have been common, as might be expected in men unaccustomed to live in tents. Only one case of pneumonia has occurred in this column and that in a man who had suffered from it before. Rheumatism is also met with, but almost invariably of the muscular variety; four men who had suffered previously from chronic articular rheumatism were sent to the rear from the Grenadiers. The sufferings from cold and exposure on the north shore of Lake Superior were most intense, but the men bore up with a most cheerful uncomplaining spirit and no serious trouble arose from it. The most trying part of the journey was the night march on the honey-combed ice, of ten miles to Red Rock, in a blinding rain storm. The men were so exhausted that some went to sleep standing up.

The supply of food has been ample and of good quality, but there has been a great dearth of vegetables, canned or otherwise. Lime juice ought to have been sent to supply their place if unattainable. Common salt is also scarce. Oatmeal would be a boon to the troops. Milk can be occasionally had at 50 cts. per quart and butter at \$1 a pound. The scouts bring in captured cattle which keeps us supplied with fresh meat. The difficulty in obtaining fresh supplies can be imagined when I mention that we are 230 miles from the nearest railway station and in an enemy's country, where the people are forbidden by the rebels to sell us anything on pain of death. We are obliged therefore to help ourselves whenever the opportunity presents itself.

The medical officers with this column are Dr. Orton, P. M. O., Drs. Codd, Grant, Whiteford and myself. I have also eight trained ambulance men under me, with Hospital Sergt. Hazelton belonging to the Grenadiers. They have proved of great use in the recent troubles, and I should urge on all medical officers the formation of such a corps in their regiments; one or two men per company, with one regulation stretcher to every four men is sufficient. The wounded in the battle of Fish Creek were promptly removed to the rear by the bandsmen of the 90th Battalion. They showed great devotion and courage, and were often under fire, as were also the surgeons in going to the front to arrest hemorrhage. I would particularly mention Drs. Whiteford and Grant.

The case of Lieut. Morrow, who was accidentally shot by Mr. Fox, *Mail* correspondent, at Camp

Desolation, is interesting. The ball entered the thigh at its anterior and inner aspect, ran under the skin for about six inches, there the probe stopped. As I could feel no ball I cut down on the end of the probe and found that the probe then took a direction downwards and backwards towards the buttock. I passed the probe in its full length, seven inches, and as I could feel no ball I determined to leave it, especially as he had to travel 60 miles in an open sleigh to get to Dog Lake Hospital. The first direction of the ball was towards the middle of Poupart's ligament, and it is most curious and providential that it should have taken a turn at an obtuse angle and passed into the back of the thigh. A somewhat similar case is that of Pte. Swan, 90th Batt., who was shot at the battle of Fish Creek, April 24th, in the inner side of the left arm at its middle third just over the brachial artery. The ball passed beneath the skin under the edge of the deltoid and disappeared in the axilla. No irritation had occurred a week after the wound had been received. The wounds in this action were nearly all given by large round balls from smooth-bore shot guns. They caused great bruising and crushing of the tissues. Their course was often circuitous. Pte. Kemp, 90th Battalion, was struck just to the outer side of the femoral artery as it enters the thigh. The missile passed between the muscles of the abdomen, followed around the loin and lodged in the muscles of the back. There was cellulitis but no peritonitis. A curious case was that of Lieut. Swinford, who was shot the same day. The ball struck him at the temporo-frontal suture, about two inches above the zygomatic process. The skull was extensively fractured, and there was hernia cerebri, but he was conscious and rational. In this state he continued with occasional nocturnal delirium for five days when his speech became impaired, and he died on the sixth day with symptoms of pressure. At the *post mortem* the ball, a large round one, was found imbedded in the brain at a depth of about two inches. Some portions of bone were found driven in. The skull was extensively fractured on the injured side.

A son of our esteemed confrère Dr. Canniff, was wounded in the same action by a round ball. The projectile entered the posterior surface of the right forearm about three inches from the olecranon process on the radial side and lodged an inch above it. As the arm was in extension at the time it was

wounded, and as no opening could be found into the joint, it is believed that it escaped.

Three amputations were performed, two through the middle of the arm and one at the surgical neck of the humerus, also one excision of the elbow joint shattered by a shot, but vessels intact. All were doing well when they left for the base hospital at Saskatoon, on May 1st. The total casualties were 31 wounded and 10 killed, including 1 officer killed and 3 wounded. The wounded were transported to the rear in stretchers made of hides slung in waggons. They were all comfortable on starting.

Camp, Fish Creek, N. W. T., May 2nd, 1885.

### Reports of Societies.

#### HAMILTON MEDICAL AND SURGICAL SOCIETY.

May 5th, 1885.

Dr. Stark, Vice-President, in the chair.

Dr. Mullin exhibited a pathological specimen—an ovum of two months.

Dr. Leslie then read a paper on "The Germ Theory." The paper went very extensively into the subject from a theoretical point of view, dealing with the researches of different observers as to the nature of cells, and from these proceeding to a description of the various kinds of germs. The subject of spontaneous generation was then taken up and the question of disease germs was considered. After a lengthy description of Lister's views and system, and the various opinions with regard to it, reference was made to Koch's investigations as to the nature of cholera and the discussions that had arisen. Drs. Mullin and Malloch both supported the germ theory, the latter especially speaking with reference to Listerism, which he considered to be increasing in favour and had exerted a beneficial influence. Dr. Rosebrugh gave the particulars of an interview had in Edinburgh with Keith as to the sufferings of the latter when using the carbolic acid spray, and the necessity arising for its discontinuance. Dr. Rosebrugh also spoke of his observations in London and Birmingham, all of which tended to show how much operations now depend on cleanliness. Dr. Leslie, in responding, stated that though at present he thought the evidence was against the germ theory, yet the growth and multiplication of germs in the body was a strong argument in its favour.

May 12th.

The President, Dr. White, in the chair.

Dr. Malloch presented a pathological specimen—carcinoma of the pyloric end of the stomach. Dr. McCargow showed a finger which had been opened for whitlow, but too late, as there was denudation of the cartilage of the articular ends of the first phalanx and the adjoining metacarpal bone of the left fore-finger, while there had been a large abscess formed under the pectoral muscles of the same side extending from the axilla, its original site, to within an inch or two of the sternum, and extending downwards over a space corresponding to three or four ribs.

Dr. Rosebrugh then read a short paper on "Intra-uterine Medication." The paper began by referring to the fact that in the greater number of cases of apparent disease of the inner surface of the organ there is, as a rule, some special cause for the symptoms, such as a flexion or version, which removed, the symptoms will soon disappear under very mild treatment. Consequently in all uterine diseases great pains should be taken to make a correct diagnosis, for experience shows that when the case is thoroughly understood the treatment is simplified and more easily accomplished. As an instance, was given the alarming symptoms presented by a case of chronic retroflexion with laceration of the cervix, so easily relieved if these primary conditions are only remedied. The class of cases requiring intra-uterine medication were summarized as follows: 1st, chronic endometritis with the following characteristics: general enlargement of the body of the organ; considerable dilatation of the corporeal cavity, and the endometrium in a condition of fungoid or cystic degeneration, giving rise to a muco-purulent leucorrhœa and frequently to a profuse menorrhagia. 2nd, uterine catarrh, with an albuminous secretion that persists, despite ordinary treatment. 3rd, habitual abortion, independent of syphilis and ovaritis, and seemingly due to some morbid condition of the endometrium. 4th, membranous dysmenorrhœa. 5th, the flabby uterus frequently associated with subinvolution. Having spoken of the difficulty of separating the treatment of the endometrium from that of the os and cervix, while often if the disease of the latter is removed there is no further trouble with the former, the essayist stated that he no longer used tents to dilate the cervical canal, as he found that the applicator

or curette could be introduced without any previous dilatation. If any was needed, the steel dilator could easily effect it. He stated that he had never used strong caustics in the solid form, though where the endometrium is decidedly diseased it becomes more tolerant of heroic treatment; but in such cases he found the most effective agent to be the fuming nitric acid. This he applies by means of the cotton-wrapped applicator, guarded by a glass tube through the cervix, the lining membrane being pretty well swabbed. Except in obstinate cases, and then only at long intervals, the application has not to be repeated. Never had he seen colic or the other alarming symptoms frequently generated by crayons of strong, solid caustics. Churchill's tincture of iodine has been proven one of the most efficient applications, its action being that of a local stimulant to uterine contraction and a general alterative or nutritive. Nitrate of silver he seldom employs, because of its severity as an astringent to the small blood vessels, and its continued use causing too much contraction of the os and cervix. Its use should be confined to the soft flabby uterus with enlarged patulous os and profuse cervical discharge, its contracting effects being carefully watched. Carbolic acid and glycerine, one part to three, is a favorite mild application, the acid coagulating the albuminous secretion while the glycerine depletes the congested condition of the parts by causing a profuse watery discharge. Persulphate of iron is also a favorite with him when wishing to produce an astringent effect upon a granulating surface. Tannic acid is also a useful mild astringent, but has, like iron, the disadvantage of discoloring the patient's underclothing. Paquelin's cautery and the actual cautery he had no personal experience of, having always effected his purpose by other methods. Intra-uterine injections he considered of service sometimes, but on account of the pain and violent symptoms sometimes following, thought milder methods should be adopted. In old chronic cases, with the uterus decidedly enlarged and diseased, and the os flabby and patulous, the organ is so tolerant of manipulation that even injections may be employed with comparative safety. Whenever fluids are to be injected the cervical canal must be straightened and enlarged so as to admit Chamber's reflex current catheter, or some such device, which will secure a free return of the fluid. A safe method is the use of a small

graduated hard rubber uterine syringe having a long slender nozzle. The syringe having been filled with the fluid to be used, the nozzle is loosely wrapped with absorbent cotton and introduced within the cavity, and then injecting carefully and slowly just sufficient to saturate the cotton, the syringe is slowly rotated so as to swab the whole inner surface. But as injections offer no marked advantage the essayist thinks they should be abandoned, or certainly very rarely employed. In some cases caustics and astringents effect only partial cure. In obstinate endometritis with fungoid degeneration a muco-purulent discharge and long continued menorrhagia, energetic measures are necessary. The denudation of the endometrium must be penetrating. The most effectual method is by thorough curetting. The uterus should be firmly held by tenaculum or vulsellum forceps and the rough portions scraped out without any previous dilatation of the cervical canal. During the curetting, one hand should be placed over the uterus externally, pressing it down so that every part of the inner surface can be reached. The cervix becomes more tractable so that subsequently a larger curette may be employed if necessary. After the denudation the inner surface is to be thoroughly swabbed with fuming nitric acid, Churchill's tincture of iodine, Monsel's solution of iron, or some other agent of a penetrating character. Local treatment must be supplemented by constitutional. Aim at reducing the enlarged uterus by ergot and strychnine, followed by tonics, quinine and iron. In old chronic cases the curetting may have to be repeated two or three times after the menstrual periods, for, do what we will, relapses will occur, so that the treatment must be persevered in. In treating these disorders the constitutional element must be considered, for in some cases both local and constitutional causes are met with, and in most cases constitutional treatment is of great service, but we must aim to remove the cause, whether local or constitutional. Dr. Rosebrugh said that the frequency of the application depended upon the agent employed—as a rule every fourth or fifth day; if the patient came from a distance, once a week. He nearly always employs the cotton-wrapped applicator, and in order to thoroughly cauterize the surface makes two or three applications at each visit. In many cases where the endometrium seems involved he restricts the application at first to the

cervix, and this with constitutional treatment proves sufficient to induce uterine contractions, and the improvement is continuous until a complete cure is effected. When the inner surface is roomy, and the os very patulous, admitting applicator readily, he pushes the applicator into the cavity and swabs the inner surface and then swabs dry with absorbent cotton the cervical portions of the uterus and vagina. A tampon of absorbent cotton, moistened with glycerine and having a withdrawing string attached, is left in the vagina a few hours. In the discussion which followed, the members differed on the following points :

Dr. Malloch thought more attention should be paid to malpositions of the uterus, and that when these were remedied only mild topical applications were necessary, such as hot water.

Dr. Mullin thought the uterus should be regarded as amenable to medical influences as other internal organs to which topical treatment could not be applied. Local treatment might be useful in certain conditions, but in his experience the conditions which give rise to menorrhagia were not always to be benefited by local treatment, on account of the pain suffered from intra-uterine applications, and after these applications had been abandoned he had found some patients much benefited and restored to health by rest, especially during and after the menstrual period, and the use of general remedies.

Dr. Stark said that while he agreed with Dr. Rosebrugh in his treatment, he preferred to treat the patients at their own houses so as to have the benefit of rest at once. He expressed himself as being at first astonished at Dr. Rosebrugh's heroic use of the curette. Since then he had had great success with it.

Dr. Ryall referred to the fact that formerly the great object in treatment seemed to be the dilatation of the cervical canal, while now gynæcologists sought by means of trachelorrhaphy to close up the canal, and in conclusion he said he wondered what became of women fifty years ago, before the days of dilatation and contraction and other special treatment.

#### ST. LAWRENCE AND EASTERN MEDICAL ASSOCIATION.

A meeting of the members of the St. Lawrence and Eastern Territorial Division was held in Cornwall, January 27th, 1885. Present :—Drs. Bergin (chairman), McMillan, Brouse, Moore, Easton. Pickup, Pringle, Alguire, Munro, Harrison, Hamilton, Gravely, S. A. Hickey, G. C. Wagner, Davis, Reddick and Lefevre.

The chairman addressed the meeting upon the

following subjects : the proposed increase of the annual fee to the Council, the advisability of raising the standard of medical education particularly in preparatory examinations, the Imperial Medical Act, the establishment of a code of ethics, and revision of the tariff.

The following resolutions were carried :—That in the opinion of this meeting it is not advisable that the annual fees should be increased to \$5, as proposed by the Medical Council.

That this meeting disapproves of Universities and Colleges having no medical schools in connection with them, being represented in the Medical Council.

That this meeting approves of raising the standard of the matriculation examination. That candidates for matriculation should be obliged to present credentials of matriculation in arts from any Dominion University, which will entitle them to matriculate in medicine upon payment of fees.

That this meeting sincerely hopes and requests that the Medical Council will take such steps as shall forthwith give to this province a legal code of medical ethics.

That this meeting feels very strongly the injustice of being obliged to register Imperial graduates without examination, a privilege we deny our own graduates, and that we desire the Council to take such steps as may be advisable to obtain justice in this matter.

That it is desirable to have a taxing master appointed for each Territorial Division.

That the registered medical practitioners resident in the St. L. & E. Division do now form themselves into an Association, to be known as "The Medical Association of the St. L. & E. Division, the officers to consist of a president, two vice-presidents, a secretary and a treasurer ; the president to be the representative of the Division in the Ontario Medical Council, and the other officers to be elected annually. The following were elected :—Dr. Bergin, President ; Drs. Brouse and McMillan, Vice-presidents ; Dr. Lefevre, Secretary ; Dr. Moore, Treasurer.

A committee was appointed to revise the tariff, and their report being adopted, the Secretary was instructed to forward it to the Territorial representative, to be submitted by him to the Medical Council for approval at the June meeting.

J. M. LEFEVRE, M.D., Sec.



## Selected Articles.

### REVIEW OF THE GROWTH OF McDOWELL'S OPERATION IN 1809.\*

BY R. S. SUTTON, M.D., LL.D., PITTSBURG.

In the bleak cold of a December day, in 1890, a woman riding on horseback, arrived in Danville, Kentucky. She had taken farewell, perhaps forever, of relatives and friends, and had just completed a journey of sixty miles that she might be near a surgeon, who had promised to open her abdomen, and endeavor to remove a large ovarian cyst it contained. She was to be the subject of an experiment—an experiment at the hands of a surgeon living on the borders of civilization—an experiment which would involve her life, and to which she must submit without the blessing of chloroform or ether. This woman possessed of marvellous courage was Mrs. Crawford, McDowell's first patient in ovariectomy, and the first patient on whom the operation was ever deliberately undertaken. She recovered and lived to the advanced age of seventy-nine years, a period of thirty years beyond the operation.

The conditions surrounding, and forming part of this operation, are worthy of more than a passing notice. At the present time, they are declared by the ablest operators to be of more than accidental importance.

In the light of all the recent advances concerning the environs of an ovariectomy patient, I ask you to listen thoughtfully, and inquire of yourselves: Have modern operators had better environments than McDowell? Is their quarantine better than his was? Whether accident, or necessity, or the simplicity of border life, provided these conditions so favorable to recovery, your orator will not inquire, but hopes to show that McDowell did operate under conditions as favorable as does Dr. Keith or Mr. Lawson Tait.

1st. The patient was refused operation in her own home.

2nd. She was operated upon in Dr. McDowell's own house.

3rd. History mentions but one assistant present at the operation.

4th. The patient had never been tapped.

5th. We may safely infer that the room in which the operation was performed, contained, at this early date in Kentucky, no superabundance of furniture or upholstery.

6th. That the room was ventilated by an open fire-place is more than probable.

7th. The atmosphere was that of a healthy border town.

8th. No sponges were introduced into the abdomen.

9th. He ligated the pedicle and dropped it in.

This operation will stand the criticism of the most exacting specialist of the year 1885, save in two particulars: viz., the ligature was not carbolized or scalded, the ends of it were left hanging out of the lower angle of the wound, and merely turning the woman on her side to permit all fluids to escape from the cavity of the abdomen was scarcely enough in that direction.

The incision was made on the left of the rectus muscle, but in his next case McDowell made it in the linea alba, between the umbilicus and pubis.

Pause a moment! Think; at the end of almost three-quarters of a century, the operation stands almost where McDowell left it, with one solitary exception, viz., the ends of the ligature surrounding the pedicle are cut short.

Restless human nature, not satisfied sought other means of treating the pedicle, a review of which is fraught with good instruction. For eleven years the operation remained in the hands of McDowell, and he adhered to ligation of the pedicle, leaving the ends of his ligature hanging out at the lower angle of the wound. In 1820, Chrysmar, of Württemberg, tied the pedicle in two portions, leaving the ends of the ligature hanging out at the lower angle of the wound. In 1821 Nathan Smith, of New England, tied the pedicle with "strips cut from a kid glove;" he cut the ligature off close to the knots, and dropped the pedicle into the abdominal cavity.

Neither Chrysmar nor Nathan Smith knew anything of McDowell's operations. Were the teachings of Hunter and John Bell working upon other minds, as well as upon the mind of Dr. McDowell? The last named sent to Mr. John Bell, of Edinburgh, an account of his cases. Mr. Bell being then in Italy, his colleague, Mr. Lizars, received the report. It is probable that this record was received in 1818. For six years Mr. Lizars kept it to himself. He attempted ovariectomy four times, and succeeded in one case, the patient surviving the operation seventy days. In one case he opened the abdomen by an incision reaching almost from the ensiform to the pubis, and thrust his hand into an empty belly. He requested every one of his students to put his hand into the abdomen, and finally exclaimed, referring to an army officer present, "Where is the military gentleman?" and had him make the same manual exploration. Mr. Lizars then closed the wound, *and it healed by first intention.*

Owing to the fact that Mr. Lizars's results were bad, twenty years elapsed before ovariectomy was again attempted in Scotland. In 1845, Dr. Handyside performed it. Another halt of seventeen years occurred, bringing us up to 1862, at which date but one success had been attained in Scotland.

\* The Address in Obstetrics, Am. Med. Association.

In that year Dr. Thomas Keith did his first operation.

Let us now cease the pursuit of Dr. McDowell's operation, as it was reported to Mr. John Bell, which report the latter did not live to see.

Up to the year 1843, I find the records of only eighteen completed ovariectomies in America. In this year Dr. Alexander Dunlap, of Springfield, Ohio, and Dr. John L. Atlee, of Lancaster, Pa., did their first cases, the latter removing both ovaries. Eleven years later (1855), Dr. Kimball, of Lowell, began operating. These three are now the only living pioneers of the army. May they live long to enjoy the distinction!

The operations in the United States were already numerous, and the stability of the operation secured. This was before Sir Spencer Wells did his first ovariectomy.

It is estimated by Peaslee that up to the last quarter of 1863, over three hundred ovariectomies had been done in this country. At this date, Dr. Keith was only beginning in Scotland; the operation was performed for the first time in Russia, and was only a year old in Italy. Twelve years after the death of Dr. McDowell, in 1842, Dr. Charles Clay, of Birmingham, England, did the first operation in that country; prior to this time, Jeaffreson, Walne, King, and West had each removed by abdominal section, parovarian cysts. In 1851, Baker Brown began operating in St. Mary's Hospital, London; his results were not good, and the intense opposition of his colleagues drove him from the hospital; he then founded "The London Surgical Home," where his results compared favorably with those of any other surgeon of his time. *It was mainly due to his action that the practice of performing ovariectomies in large hospitals, where isolation is impossible, ceased.*

From Baker Brown, Nélaton learned the operation by personal observation, and returning to France, related, in a public lecture, how he had seen Brown do five cases, three of them in a single day; and thus through the influence of Brown on Nélaton, the opposition to ovariectomy in France was largely diminished. In 1854, Baker Brown taught Sir Spencer Wells the operation, and in 1857 Sir Spencer did his first operation. In 1864, according to Sir Spencer Wells, the operation was completely established in London, and, we may add with pride, in every country in the civilized world.

But while the surgical world recognized the operation, there was a diversity of opinion with regard to the treatment of the pedicle. From the date of Dr. McDowell's first operation up to 1821, when Dr. Nathan Smith operated, the ends of the ligature were brought out at the lower angle of the wound; Dr. Smith was the first to cut the ends off. For sixteen years after, no other method was offered. In 1837, Stilling of Cassel, in the province of

Hesse-Nassau, Germany, used the cautery, and suggested stitching the pedicle to the wound.

Nine years barren of new suggestions again elapsed, when, in 1846, Dr. Handyside, of Edinburgh, Scotland, carried the ligatures through the cul-de-sac of Douglas into the vagina. In 1848, Stilling treated the pedicle outside of the peritoneal cavity. Two years later, in 1850, this method was inaugurated in London by Mr. E. W. Duffin. The introduction of the extraperitoneal method of treating the pedicle by Stilling, in 1848, began a long and serious conflict which has happily died out with the method. Maisonneuve, of Paris, in 1849, had twisted the entire pedicle in one case, and Martin of Jena, had stitched the pedicle to the wound. About this time Langenbeck stitched the pedicle to the wound, and covered it with the skin from the margin of the incision.

Eight years later, in 1850, Dr. John L. Atlee, of Lancaster Pa., introduced the *écraseur* to divide the pedicle. He was imitated by a number of prominent operators, notably by his brother the late Washington L. Atlee, Sir Spencer Wells, Dr. Keith, Professor Pope, of St. Louis, U. S., and Professor Billroth, of Vienna. This year proved unfortunate for the operation, for during it Mr. Jonathan Hutchinson invented the clamp which perpetuated the extraperitoneal mode of treating the pedicle. In 1860, Sir James Y. Simpson secured the pedicle within the cavity of the abdomen by acupressure needles passed through the abdominal wall. About 1865, Koeberle, of Strasburg, invented his *serre-nœud*, or wire constrictor, with which he grooved the pedicle prior to applying the ligature.

In 1864, Mr. I. Baker Brown, of London, reverting to Stilling, of Cassel, established the use of the cautery, a method rejected in London, taken up by Dr. Keith, and now credited through him with the best statistics yet attained by any operator. In 1868, Masslovsky, a Russian, amputated the pedicle by double flaps, one on each side, and stitched the flaps together. In 1869, Dr. McLeod, of Glasgow, Scotland, by means of two pairs of strong forceps, twisted the pedicle entirely off. During this year, Dr. Peaslee invented a scabbard and knife by means of which the pedicle was secured, the ligature traversing the scabbard. After forty-eight hours the ligature was cut by introducing the knife into the scabbard, when both ligature and scabbard were withdrawn. In 1870, Dr. Thomas Addis Emmett reported eighteen cases in which he had secured the pedicle by means of silver wire.

Up to the present year (1885), every conceivable thing has been done with the pedicle. It has been tied entire; tied in sections; been twisted off; burnt off; crushed off; cut square off; cut off in flaps; left inside; left outside, and then made to slough off. The extraperitoneal method of treating the pedicle is gone. The question is now resolved into the merits of the ligature

cut short, the Dr. Nathan Smith method, or the clamp cautery, as introduced by Mr. I. Baker Brown, of London, in 1864. If the clamp as devised by Mr. Jonathan Hutchinson was a bad instrument, and according to Mr. Tait, reduced the statistics that Sir Spencer Wells should have attained, it must have similarly affected the results of those who have employed it in the United States. Recently ligation and the cautery have given almost equal results.

The operation of Dr. McDowell in so far as it relates to the treatment of the pedicle, is, therefore, triumphantly where he placed it, despite the ingenuity of the surgical world, having undergone but a single alteration, namely, Dr. Nathan Smith's improvement of cutting the ligature short. I have not been able to learn anything as to the extent sponges were used by the pioneer operators. When Dr. Keith was about to do his first operation, he had the water to be used boiled the night before, and he made everything scrupulously clean; during the operation he was surrounded by old practitioners.

After removal of the cyst, he thrust a big sponge into the abdomen, and brought it out full of fluid. As he was about to repeat this, one of the doctors seized his arm, and exclaimed, "For God's sake don't do that again." While he hesitated, the others argued that any fluid left in the body would be a nice protection to the intestines. He closed the wound. Subsequently the patient did badly. He at once opened the wound and let out a pint of dirty fluid, and the patient recovered. From that time he advocated careful sponging after the operation, *and he was the first to insert a flat sponge under the wound while the stitches were being placed.* Koeberle, who also began to operate in 1862, *introduced the compression forceps and drainage, first by short and later by long glass tubes.*

I here show you the Baker Brown cautery clamp, used by Dr. Keith, the compression forceps of Koeberle, *also the modification of Sir Spencer Wells,* and the drainage tubes so much in use by operators in great Britain.

The technique of McDowell's operation is, probably complete, *and its future will depend on the subject, the place of application, and the care taken to protect the patient from extraneous sources of danger.* It may be compared to a mighty oak, each decade of years having added to its greatness until its far-reaching branches furnish shelter for the thousands of men and women who require abdominal section. Its ramifications are hysterectomy for fibroids, hepatotomy, cholecystotomy, normal ovariectomy, the Hegar-Tait operation for the removal of both ovaries and tubes, nephrectomy, exploratory incisions, gastrotomy, and enterotomy. It still continues to grow, and the task of pointing out the leaves that have been added to its foliage during the last year requires our efforts ere they

fall about the roots and contribute themselves to the growth of the parent tree.

Valuable lectures and papers have been given by Dr. Keith, M. Lawson Tait, Mr. Savage, Sir Spencer Wells, and Mr. Bryant, all in the *British Medical Journal*.

The results of valuable experiments on lower animals have been published by Prof. C. T. Parkes, of Chicago. Many successful cases of the Hegar-Tait operation done by our countrymen, and the surgeons of Great Britain, have been published in various journals.

Mr. Thornton has been successful in gastrotomy for the removal of a large foreign body, and has had seventeen successful cases of nephritic surgery ten of these being nephrectomy by abdominal section. Drs. Keith and Bantock continue to do supravaginal hysterectomy with unparalleled success, and it is premised that if their success continues, it will elevate their method of operating beyond the reach of controversy. They both adhere to the extraperitoneal treatment of the stump, while the continentals practise the intraperitoneal method.

The recent visit of Mr. Lawson Tait to the United States, has given great impetus to the Hegar-Tait operation for the removal of diseased tubes, and for the removal of ovaries and tubes for the cure of fibroids of the uterus.

For the purpose of encouraging the conservative abdominal surgeons, *those who look carefully to the environment of their patients,* I point with great pleasure to the fine statistics of Dr. John Homans, of Boston, and of Dr. Robert Battey of Georgia, whose early initiation of normal ovariectomy was suggestive eventually of the Hegar-Tait operation which included the tubes.

Ovariectomy and its offshoots comprise almost, if not the entire field of abdominal surgery. The establishment of the parent operation brought out the others, if not for the first time, it revived and established them after they had been practically abandoned. "The seed sown by Bell and Hunter, carried by McDowell, and planted in Kentucky;" its first growth was slow, but gathering strength from the passing years, its top has risen high, and its great branches cover a wide space, where unfortunate men and women of every land and clime gather to find relief from suffering and to acquire new leases of life.

The carbolic spray is still a matter of dispute. In Great Britain, Mr. Thornton adheres to it as of old, Drs. Keith and Bantock, and Mr. Tait will have none of it. The latter said to me, "I sold out all my right, title, and interest in Listerism, with my tea-kettle to Battey."

*So far as I know the best statistics yet obtained in ovariectomy in the United States belong to Dr. Battey, of Georgia, and Dr. John Homans, of Boston, Mass., both of whom operate under the carbolic spray,*

*and in apartments kept especially for abdominal operations.* I make special mention of the fact that these gentlemen use the carbolic spray, for the reason that Dr. Emmett says, in his last edition, p. 715, "I do not know of any prominent operator in this country who now uses the spray," evidently an oversight.

I do not use the spray myself, but look upon the entire Lister system, less the spray, as firmly grounded in the surgical mind. Cleanliness and Listerism can never be separated, for "Listerism is the gospel of cleanliness;" without the latter you cannot have the former.

The year has wrapped up in its eternal folds one whose name is synonymous with the surgery of women; whose reputation is immortal, who in America at least, stood next to McDowell; beloved by his own countrymen honored by the entire surgical world. No eulogy of mine can increase his fame. I speak of *the great, the good, the pure, the noble, the generous* Marion-Sims. Like McDowell, he possessed a genius for origination, and will share with him the admiration and plaudits of future generations.—*Med. News.*

## HYPERTROPHY OF THE PROSTATE.

The gradual invasion of symptoms of urinary obstruction in a man of advancing age would always suggest the probability of hypertrophy of the prostate. But the existence of this condition may be demonstrated by a digital examination. The patient is placed in a supine position; the surgeon stands on his left side, and introduces at least two phalanges of his left index finger, slowly and gently into the rectum, while the patient's knees are flexed and separated from each other. The surgeon examines whether the enlargement involves one or both lateral lobes, equally or unequally, whether it affects chiefly the breadth or depth, whether it is soft or hard, regular or irregular, solid or fluid; whether fluctuation can be felt in the bladder behind the prostate. He should also examine as to tenderness on pressure, its degree and locality: he should also estimate the temperature of the parts. Prostatic calculi can sometimes be detected by the finger. While making these examinations with his left hand, he should introduce a catheter with his right hand, while the left index finger judges as to the thickness of the intervening tissues. The catheter should be of as large size as the calibre of the urethra will allow. If urine flows freely when the catheter has not penetrated more than  $6\frac{1}{2}$  to  $7\frac{1}{2}$  inches, and the handle is not much depressed, it is fair to infer that there is not much enlargement of the prostate. If the catheter has passed 8 or 9 inches, and the urine does not flow until the handle is considerably depressed, there is good evidence of prostatic enlargement. A pros-

tatic catheter, longer than the ordinary catheter, and its beak nearly at right angles with its shaft, will be required, in such cases, to draw off the urine. Or a long soft catheter may be employed.

To explore the interior of the bladder, an instrument with a short beak, like Leroy's or Mercier's may be used.

*Treatment.*—There are three principal indications: *First.*—To obviate the results of obstruction. *Second.*—To improve the constitutional condition of the patient. *Third.*—To diminish the enlargement, or to retard its growth.

The first is the chief indication. The bladder should be evacuated as thoroughly as possible at least once in twenty-four hours. It is often desirable to do this three or four times a day. When the residual urine amounts to only two or three ounces, once a day may suffice. When it amounts to five or six ounces, the bladder should be evacuated at least twice in twenty-four hours. When the power of urinating is nearly lost, the catheter should be introduced as often as the desire to void urine is felt. The patient should be taught to introduce the instrument himself. In determining the question as to the use of the catheter, the degree of irritability of the bladder and of the urethra, and the acrimony of the urine are to be taken into account. When the urine is acrid and fetid, the bladder should be washed out with warm water, and with antiseptic lotions. The patient should be taught to use a flexible catheter, when it is practicable. But special care should be taken to avoid the use of flexible catheters which are worn or cracked, or which have their eyes deformed. The eyes of the catheter should be of full size, as the urine is often viscid, and will not flow through a small aperture.

But in some cases, a silver catheter must be used, and great care should be taken in instructing the patient, that he may do himself no injury. In using a flexible instrument a stilet six inches long may be used, stiffening the handle, but leaving the distal end flexible. When there is retention of urine, and the catheter is passed with great difficulty, it may be left in a number of days. The pressure of the instrument may, perhaps, cause some absorption of the hypertrophied part. To guard against the injurious consequences of non-evacuation or imperfect evacuation of the bladder, the use of the catheter is very important.

In cases in which treatment has been neglected and there is a very large amount of residual urine, a pint or more, it is not safe to withdraw more than half of it at once. From day to day, the quantity withdrawn may be increased, and, in the course of a week or two, the bladder may be emptied. The danger of the complete and sudden evacuation of the bladder under these circumstances was first indicated by Sir Benjamin Brodie.

When the disease has not advanced to the de-

gree which has been mentioned, there are certain complications requiring attention :

*1st.—Atony of Muscular Coat of Bladder.*—This is usually relieved in part by the regular use of the catheter. Other means may be of service. Cold applications over the abdomen twice a day. Cold injections into the bladder every day, or every other day. Electricity, strychnia, iron, ergot.

*2nd.—Chronic Cystitis.*—This is indicated by frequent and painful micturition, with pus and mucus in the urine. Relief is often afforded by washing out the bladder with warm water—100° Fahrenheit. The water may be introduced into the bladder by an India-rubber bag with a nozzle adapted to the catheter, or with a fountain syringe. But a more convenient instrument for the purpose is a hard rubber syringe, which has been constructed under my direction by Tiemann & Co., of New York, and which is known as Post's Vesical Syringe. It holds four ounces, and is of such a shape that it can easily be worked with one hand. Its distal extremity is adapted to a moveable tube, provided with a stop-cock, and tapering from a circumference of 30 mm. at the base to 10 mm. at the apex, so that it will fit a catheter of any size in ordinary use. Both ends of the syringe can be unscrewed, so that either end of the piston can be renewed by the surgeon without the aid of an instrument maker.

After the bladder has been washed out with warm water, mild astringent injections may be employed, such as mineral acids largely diluted; weak solutions of acetate of lead, nitrate of silver, etc. Hot hip-baths may often be used with advantage: also, hot fomentations over the abdomen. Counter-irritants are sometimes useful, as sinapisms and blisters. I have seen very great benefit resulting from the use of the actual cautery in the hypogastric region. Leeches may often be applied with great advantage, to the perineum or around the anus.

Internal remedies are often of service, such as *diosma crenata*, *pareira brava*, *uva ursi*, *tritricum repens*, *copaiba*, *cubebs*, *ol. santal*, demulcents. Gross recommends highly *infus. uva ursi* and hops. Alkalies often have a very soothing influence even when the vesical urine has an alkaline reaction.

*3rd.—Irritability of Bladder,* with frequent painful micturition. Opiate suppositories are often useful. *Ext. belladonna* or *hyoscyamus* may sometimes be combined with it. Opiates may also be given by the mouth. *Chlorodyne* has been given with advantage. When there is phosphatic deposit, inject the bladder with weak nitric acid once in a day or two—one or two minims to 3 j: quantity 3 i j to 3 iv. A solution of acetate of lead, gr. j to iv, to an ounce of water,—when urine is fetid, carbolic acid 1 per cent.

In cases of vesical hæmaturia, gallic or tannic acid may be given internally, gr. v or vj, ter. in

die. Mineral acids. *Ol. terebinth*, x to xv, in emulsion. Sesquichloride of iron. When hemorrhage is alarming, a bladder filled with ice may be applied to the hypogastrium or perineum. Ice-water may be injected into the rectum, or ice suppositories may be used. A collection of blood in the bladder will often obstruct the eye of a catheter when the patient is in an erect posture; but when he assumes a supine position, the blood will gravitate towards the posterior part of the bladder, and the urine will flow through the catheter. The attempt to break up the clot is likely to cause fresh hemorrhage. When there is complete retention from a clot, and symptoms are urgent, Bigelow's or Otis' Evacuator may be employed. In extreme cases cystotomy may be resorted to.

Incontinence of urine may occur; this is usually an overflow from a distended bladder, but there may be inability of the bladder to retain more than a very small quantity of urine. In either case, an India-rubber receptacle may be worn.

There is often liability to congestion and inflammation from slight causes, as exposure to cold, riding on horseback, journeying, sexual excitement, alcoholic stimulants, etc., giving rise to fever, gastric disturbance, muco-purulent or bloody discharge. Relief is afforded by warmth, rest in bed, laxatives and anodynes. In such cases, there should be great gentleness in use of catheter,—leeches around anus, dry cupping in perineum.

*General Treatment of Patients with Enlarged Prostate.*—Carefully guard against catarrh, indigestion or constipation. Diet carefully regulated—avoid indigestible food. Alcoholic stimulants should be altogether avoided or their use carefully regulated. Warm clothing, dry feet, warm foot-baths and general baths. Muscular exercise should not be neglected, but it should not be carried to such an extent as to produce great fatigue. When the patient is tired, he should rest in a horizontal position; he should avoid despondency, and keep up his spirits by cheerful society, employment and recreation.

*Special Treatment of Enlarged Prostate.*—Medical treatment has not yielded very satisfactory results. Conium, different preparations of mercury and iodine, muriate of ammonia, and various mineral waters have been recommended, but none of these remedies seem to have exerted any remarkable influence in diminishing the bulk of the prostate, or in retarding the progress of the disease. The use of ergot by the stomach or by hypodermic injection has been recommended. Henry Morris, in a paper published in the *Lancet*, December, 22nd, 1883, states that he has seen great benefit from the use of ergot. Dr. Washington L. Atlee, in an article published in *N. O. Med. and Surg. Journal*, August, 1878, gives similar testimony. Under its use, several of his patients were able to dispense with the use of the catheter. He

gave 20 drops of the fluid extract every four hours, until a decided improvement took place, and then diminished the frequency, finally giving only one dose at night.

In the *Brit. Med. Journal*, 1878, vol. II, page 500. Dr. William Bird, of York, states that he has derived great benefit from the hypodermic injection of ergotine in doses of  $\frac{1}{3}$  of a grain.

Pressure has been recommended as a means of diminishing the bulk, or retarding the growth of a hypertrophied prostate, and the use of large catheters or sounds is probably of some service in this respect.

Electricity has been recommended, but it has not realized the expectations of those who have used it.

The removal of obstructing portions of the prostate by ligature, excision or crushing has been recommended, but there is a difference of opinion among surgeons as to the expediency of this method of treatment. Gouley recommends a median incision of the perineum, opening the membranous part of the urethra on a grooved staff, and introducing a catheter into the bladder. In a more severe class of cases, he recommends the ablation of the median prostatic outgrowth. He explores the prostate by introducing a finger through the perineal section, and if a median outgrowth or isolated tumor be discovered, he enucleates the tumor, or excises the outgrowth, or removes it with a wire *écraseur*. After the removal of the tumor, he leaves a catheter in the bladder a number of days. —*New England Med. Monthly*.

## ON DIET IN DISEASE.

Dr. J. Milner Fothergill gives the following in the *Medical Times*, May, 2, 1885:

A patient amused me very much yesterday. She had been for some time getting weaker and thinner, with her liver out of order, while her medical man had been feeding her upon meat and giving her vegetable tonics and iron, but without good result. At last she suspected that the treatment did not suit her, and so consulted me. When asked to put out her tongue, she observed, "The other doctor never asked to look at my tongue." If he had, he might have been more successful with his treatment. "Has he been giving you steel?" I asked. "Yes, and it did not agree with my liver," she promptly added, evincing a shrewdness that took me aback. On vegetable tonics without iron, and much lighter food, she got on famously. Yesterday she called to report her improvement.

Some time ago, in conversation with the manager of one of the many Homes now springing up where paying patients can be nursed, the subject of feeding sick persons cropped up, and she

was very enthusiastic about "a twenty-minutes pudding," but of what it consisted did not transpire. A tentative remark about the digestion of the starchy materials of our food flew past her unheeded. It was soon clear that of any rational ideas of digestion, theoretically or practically, she was in unilluminated ignorance: all she knew was a little empirical knowledge, and of that she did not possess a superabundance. Who then, is to know this matter of feeding? Who is to tell the student of the difference betwixt raw or uncooked starch and cooked starch?—that in the latter the insoluble starch-granule is not only cracked, but the starch is largely converted into soluble dextrin by exposure to heat? that by the addition of some such soluble carbo-hydrate to meat-broths they endow these broths with a decided food-value? and that the meat-broth itself is but an agreeable vehicle for some food? Yet this is what he ought to be instructed in, if he is to be fitted to meet disease. When the patient sinks of exhaustion, of what does he die? His stores of force are run out; but what is the material which constitutes the body-force? I should read with delight a lecture upon this topic by Dr. Austin Flint or Dr. Da Costa,—or perhaps some less illustrious physician will grapple with the topic. We know that when a patient declines all food he will die in a given number of days. If a healthy person be hungered, as by shipwreck, he also will live a given number of days. In the latter case death will come all the sooner if the surrounding temperature be low. In the former case the duration of life will be shorter as the body-temperature rises. There is a question of combustion involved. It may not be the whole question, but it is an important factor! Alcohol is a readily-combustible hydro-carbon: it is used freely in critical times. Does not the idea naturally suggest itself that somehow the store of glycogen—the body fuel—is a cardinal matter? If this be so, it is evidently desirable to keep up the stock of this material so that it may not be exhausted. If raw or uncooked starch be employed, probably it is little acted upon by the diastase of the saliva, or even the diastase of the pancreas, both organs being crippled by the general malaise. But a starch which has been rendered soluble by previous baking or by the matting process has been so modified that it is highly soluble.

I do not know how the matter stands in the United States, but as regards the mother-country, little, very little use indeed is made of those prepared foods spoken of—sometimes derisively—as "Baby-Foods," either in cases of primary dyspepsia or in that debility of the digestive organs which is involved in serious morbid conditions. Yet by the addition of cooked starch, as biscuit-powder, to meat-broth, and of malt preparations to milk or milk somewhat diluted with water, foods



nutritive and at the same time readily assimilable are furnished to the sick person. Of the advantage of a fairly competent knowledge of such foods, both in their chemical elements on the one hand and in their variety on the other, probably no one can be better aware than myself: and such knowledge has been of infinite service to me, or some grave delusion exists in my mind. We must, too, remember another aspect of the subject,—viz., variety. While we are in health we are apt to growl about lack of variety in our food: how much more, then, the sick man! If the changes can be rung by different forms of meat-broths combined variously with different prepared foods, how much variety can be furnished to sick persons, and with that how much inducement to take that nourishment, so badly wanted and so hard to supply in many instances! Sago, tapioca, and rice or barley can all be placed in a slow oven and baked for an hour without scorching, and so be prepared for use in the sick-room. When the patient is convalescing, a milk pudding can be prepared of such material, which requires but little of the digestive act. Or there are various forms of plain biscuits which are admirably adapted for use with broths or soups (the Channel Islanders always thicken their soups with biscuit broken fine or powdered). By such means a good and, indeed, substantial meal can be furnished to a phthisical person with softening tubercle and a feverish temperature,—a typical instance of enfeebled digestion due to general malaise. And as for gastric catarrh or atonic dyspepsia, such a meal would not be likely either to become enfolded in a layer of mucous or to present any difficulty as to solubility. These may seem very simple matters, scarcely worth putting on paper; but the professional acquaintance with them is not as ample as it might be with advantage to invalids and sick persons. When a medical man lifts his eyebrows or protrudes his lip when “Baby-Foods” are mentioned in relation to dyspeptics and persons acutely sick, the impression he makes on my mind is this: that he has not made a study of the matter of food and its digestion, and that he has yet to learn some matters which, when acquired, will enlarge his usefulness and strengthen his hands when he stands by the bedside of his patient.

#### DURATION OF CONTAGIOUSNESS IN INFECTIOUS DISEASES.

The only attempt within my knowledge to formulate experience in respect of the duration of infectiousness, is that of Dr. Miller, of Dundee, whose tabulation is as follows:

Small-pox—14 days after termination of scabbing.  
Typhus—28 days from inception.  
Scarlet fever—7 weeks from inception.

Diphtheria—6 weeks from inception.  
Whooping-cough—8 weeks from inception.  
Measles—6 weeks from inception.

*Small-pox.*—As to small-pox, there is practically unanimity in regarding the danger as existing until all crusts are removed; but a few incline to prolong even further the period of isolation.

*Typhus Fever.*—In relation to typhus, there is less accord. One deems fomites the most important factor in the dissemination of the malady, while the rest lay stress on personal contagion. One regards it as “not contagious after a short interval;” a second advises segregation until repeated baths have followed the complete disappearance of the cutaneous exanthem; a third, somewhat indefinitely, would permit return to school “after complete recovery and disinfection.”

*Typhoid Fever.*—Those who believe in the direct personal contagiousness of enteric fever are few in number, and I fancy that nearly all of us will agree that the intestinal discharges are all with which preventive medicine has concern. Whether these retain their infectious properties during the whole process of the malady is a question still in uncertainty, and rendered more obscure by the apparent demonstration that the disorder may, under certain undetermined circumstances, be generated *de novo* from ordinary sources of filth-poisoning. At all events, isolation of the person seems unnecessary as soon as convalescence is complete.

The same considerations will apply, I believe, to cholera, with the further remark that, if Koch's recent observations are correct, the germs of this disease appear to be shorter-lived than any other known species, being destroyed not only by desiccation, but by the “scavenger-bacteria,” which conquer them in the struggle for existence in the products of common decomposition.

*Diphtheria.*—Diphtheria affords a wider debatable ground. To begin with, there are many (among whom my own experience forces me to class myself) who assign the first place in the pathogeny of diphtheria to the filth-poisoning, and doubt its exceeding contagiousness. Of a number of persons exposed to the same pathogenic conditions, it is not surprising that several should succumb; but this is not convincing evidence of transmission from one to the other, and I have seen repeated instances where, despite intimate contact, the disease failed to extend after its introduction into places in proper sanitary condition. One of my correspondents, who has long had charge of a large hospital for children, believes this malady to be feebly, if at all, contagious, and finds it quite safe to remit quarantine “after the disappearance of membranes;” a practical sanitarian, of national reputation, excluding fomites and filth in air or water, does not believe in personal contagion; a distinguished teacher in one of our metropolitan colleges doubts “its communica-



bility, except by contact ;" another, equally eminent, declares that contagiousness endures until the last trace of inflammation or infiltration secondary to the diphtheritic process has disappeared ; a fourth would protract the duration of quarantine for a month, or at least three weeks, after all symptoms had abated, and would forbid return to school while any redness of the fauces or any coryza lingers. The discrepancy of opinions in this respect among the leaders of professional thought suffices to show the need of more definite data to guide our deliberations.

*Whooping-cough.*—In pertussis, all opinions agree, save one, that contagiousness ends when the cough loses its spasmodic character, the single doubtful view being that, as the danger is wholly from the breath of the patient, it cannot be determined how long the cough may convey infection. It should be remembered, however, that a few writers have expressed doubts of the contagiousness of pertussis in any stage.

*Measles.*—With regard to measles, I find equal diversity of views. One regards its contagium as very volatile, not long adhering to person or clothing, and permits the return of the patient to school in two weeks after convalescence ; a second would defer liberation from quarantine until a week, at least, after desquamation ; a third releases the patient when desquamation has ceased, or in cases where no desquamation occurs, after twenty-one days ; a fourth fixes eighteen days ; a fifth believes the danger past when the febrile stage and eruption are gone. The majority measure the time of isolation by the process of epidermal exfoliation.

*Scarlatina.*—In scarlatina, also, we have opposing opinions, ranging from that which considers it a pythogenic disease, slightly, if at all, contagious from the person, to that which holds the infection to be communicable by the pulmonary exhalations, the blood, the naso-pharyngeal secretions, even the urine, as well as by the epithelial scales. One of my correspondents thinks the infection remains so long attached to the person, that quarantine should endure for eight weeks ; another cites an example of transmission after six weeks of isolation followed by a change of clothing ; the rest concur in releasing the patient after desquamation has ceased and the surface been thoroughly cleansed. Most of us, I dare say, have adopted this "rule of thumb."—*N. Y. Med. Journal.*

## ACTINOMYCOSIS.

Some incidental remarks made at a recent meeting of the Pathological Society revealed the existence of the first genuine instance of Actinomycosis in this country. The case occurred, we believe, in the practice of Dr. Harley at St. Thomas's Hospital, the post-mortem examination being made by Dr.

Sharkey, and the microscopical examination by Mr. S. G. Shattock, curator of the museum. As the disease in man has only been recognized within the past decade, and as no cases have hitherto been recorded in this country, it is not surprising that but few members of the profession in England should be acquainted with it. A valuable clinical contribution to our knowledge of the affection in man, has recently appeared from the pen of Dr. J. Israel.\* In 1882, professor Ponfick published an almost exhaustive monograph on the disease, in which most of the facts then known were embodied. From questions which have been addressed to us, we believe that a brief account of the elemental features of the affection will be welcomed by the majority of the profession, to whom the malady is unknown.

The affection is presumably one which is dependent on the presence and activity of a micro-organism. The micro-parasite is a member of the fungoid class, and consists chiefly of a mycelium which divides in a dichotomous fashion, and gives rise by its spread from a centre to a radiate appearance, whence its name—actinomyces—is derived. The circumferential ends of the mycelial sprouts have a flask-shaped swelling. The little masses of felted mycelium may be recognized by the naked eye as sulphur-yellow bodies of about the size of a hemp-seed. The disease which this parasite is supposed to cause may develop in many parts of the body. The most common site appears to be the jaw and parts bounding the mouth. The affection in animals has long been known in this situation under various names, and has been regarded as a form of scrofula and as a new growth. It is believed that the parasite gains an entrance through the medium of a carious tooth, or some wound of the gum leading to the jaw bone. There is but little to be said of the morbid anatomy of the disease. A swelling forms in the jaw, and gradually increases in size. This tumor in its earliest stages may be punctured without any matter being let out, although it generally has an elastic and semi-fluctuating consistence. A section made into a tumor in the early stage of its existence shows a reddish-white area sprinkled in places with gold-coloured granules. Later on abscesses and fistulae form, in the discharge from which sulphur-colored bodies may be seen. Broadly speaking, the tissue of the morbid new growth, which must be regarded as inflammatory rather than sarcomatous, has very much the characters of ordinary granulation tissue. Actinomycosis may occur primarily in the respiratory tract proper, and Dr. Israel makes this class of cases his second group. He narrates a case in which the disease was localized to the bronchial mucous membrane. The patient was a girl aged fifteen, who suffered from the signs and symptoms of chronic bronchitis,

\* Klinische Beiträge zur Kenntniss der Actinomykose des Menschen. Berlin : A. Hirschwald.

with fetid expectoration, in which the actinomyces were readily discovered. Another case of a man, aged twenty, is given, in which the primary localization of the disease was in the parenchyma of the lung; it was afterwards propagated to the pleura and to the prævertebral tissues. Some of the cases have many of the clinical characters of empyema with discharging sinuses, and in such cases a complex system of fistulæ not unfrequently undermines the morbid tissues. The structures in the posterior mediastinum and prævertebral regions are often affected, and the bodies of the vertebræ may become carious. Dr. Israel makes his third group of cases include those in which the disease begins primarily in the intestinal canal. In some of the cases the foci of the disease are widely disseminated. The liver, spleen, muscles of the back, and muscular substance of the heart have been shown on post-mortem examination to have numerous centres of actinomycosis. Large abscess cavities may form behind the peritoneum as well as behind the pleura, and these may communicate by many perforations of the diaphragm. The symptoms necessarily depend chiefly on the localisations of the disease as well as on its rate of progress, and present therefore extremely varied clinical pictures. Dr. Israel's work contains an account of thirty-eight cases, which number includes all that have hitherto been recorded.—*Lancet*.

[Dr. J. B. Murphy, of Chicago, reported two cases in the human subject, before the Chicago Medical Society (*Chicago Medical Journal*, March, 1885). In both the disease attacked the lower jaw, and the peculiar sulphur-colored granules were readily recognized. Both patients recovered. These are probably the first cases which have been recognized on this continent]—ED. LANCET.

**TREATMENT OF RINGWORM OF THE SCALP.**—The following is a very simple and effectual method of treating ringworm of the scalp.

The child affected is made to sit down before a wash basin half filled with warm water. A folded towel is first of all tied around the child's forehead, in such a way that no fluid poured on the head can trickle into the eyes.

It is best to cut the hair short all round the affected part. If there be many spots of ringworm, the whole head may be closely cropped. Have ready a two-ounce bottle of common spirits of turpentine, an ounce bottle of tincture of iodine, a camel's hair brush, and cake of 10 per cent. carbolic acid soap.

While the child bends forward over the basin, the spirits of turpentine is freely poured over one or more spots at a time, the forefinger being used to rub the turpentine well into the scalp. Almost immediately the dirt and greasy scabs disappear, and the short broken hairs are seen to stand up

like bristles. Generally, in about three minutes time the child cries out "Oh, it nips!" and we know the turpentine has penetrated deeply. Immediately the piece of carbolic acid soap is rubbed well into the parts which have been acted on by the turpentine, and warm water is freely applied to make this soap into a lather, by which means the head is well washed, and soon appears to be beautifully cleaned. The smarting, such as it is, quickly disappears. The head is then well dried with a towel. Common tincture of iodine, in two or three coats, is now painted well over the affected parts, and allowed to dry. As soon as the hair is dry, some carbolic oil (1 in 20) is rubbed through the hair to catch such spore as may be there.

This treatment, applied every morning, or morning and night in very bad cases, generally cures the worst cases in the course of a week. During the last five years I have used no other method of treatment. The explanation of its success is as follows: common spirits of turpentine is a powerful germicide, but is a still more powerful solvent of the sebaceous or greasy matter of the scalp, and it rapidly penetrates into all the epithelial structures of the scalp, the affected hairs included, and clears the way for a more powerful germicide, namely, the tincture of iodine.

It is an interesting chemical fact that spirits of turpentine, or more correctly, oil of turpentine, is a powerful solvent of iodine. This quickly destroys the fungus of ringworm. If tincture of iodine be applied to the spots which have been treated as above, first with the spirits of turpentine and then washed with carbolic acid soap and water, it finds its way down into the epithelial structures, and into the hair-follicles, following the course which the spirits of turpentine has taken. It is of no use to apply watery solutions of germicides until the sebaceous or greasy matter of the scalp has been first removed.

In some severe cases I have used a solution of iodine in turpentine, ten grains to the ounce, instead of the tincture of iodine, after the head has been washed and cleaned; but in most cases the use of tincture of iodine, after the part has been acted on by spirits of turpentine as above described, is quite sufficient to destroy the disease.

Ringworm of other parts of the body may be treated with spirits of turpentine and tincture of iodine in the same way. One great advantage of this treatment is that it may be used on the head of the youngest child, and causes little or no distress at any time.—*Brit. Med. Journal*.

**RAPID ANÆSTHESIA BY ETHER.**—Dr. A. F. Müller says in the *Med. News* April 4th: "The following method of rapid anæsthesia by ether was suggested to me seven or eight years ago by a thought that the great length of time often consumed in

etherizing patients was due to the fact of the frequent interruptions necessary to replenish the cone or towel used for the purpose, and the consequent partial recovery of the patient. To obviate the difficulty and obtain a continuous flow of pure ether vapor, I have made an apparatus, consisting of the two valves of a rubber football sewed together at the edges and connected by a tube with a bottle containing ether, which is plunged into a bucket of hot water. Ether boils at  $98^{\circ}$ , and vapor passes over steadily and rapidly, and is inhaled by the patient, whose face is covered by the inhaler, protected by a clean towel.

The result has been surprising, as will be seen by the following cases, all etherized by this method within the last three months at the Germantown Hospital. In none of the cases was there nausea previous to anæsthesia; one at least came to the house the morning of the operation having eaten a hearty breakfast. In most cases no struggling, and if so, only slight; no stage of excitement. In cases that require only a few moments for operation, the patient wakes up as quickly as after nitrous oxide. After patient is etherized, the amount passing over can be regulated by a stopcock at the bottle end of the tube.

The apparatus I have used is very crude, made only for the purpose of experiment, and I am having an improved one made, which I hope will be more satisfactory in its details."

The quantity of ether used to produce complete insensibility in no case exceeded three ounces; in some it was less than an ounce and a half. Dr. Müller reports 18 cases in which unconsciousness was produced in from 30 seconds to 2 minutes.—*Maryland Med. Journal*.

**KUSSMAUL'S COMA.**—Dr. Saundby read a paper on Kussmaul's coma before the Midland Med. Society, based upon two recent cases. He ascribed its symptoms, drawing attention to the peculiar character of the dyspnoea as constituting a distinguishing feature of pathognomonic significance. He especially insisted upon the fact that this form of coma was not restricted to diabetes, one of the cases related being an example of its occurrence in advanced renal disease. He referred to the various theories which had been advanced to explain it, and stated precisely the exact position of the acetonæmia question. He explained the methods used for testing the acetone, and showed Nobel's test with nitro-prusside of ammonia. In his opinion, the symptoms were due to the action of some poison nearly allied to acetone. He referred to Minkowski's suggestion that they might be the result of de-alkalization of the blood from the presence of some acid in great excess. After discussing the predisposing and exciting causes and the diagnosis, he pointed out that it was not invariably fatal. Treatment in the earlier stages should be

elimatory, by purgatives, if the bowels could be got to act, and later on the intravenous injection of a neutral saline solution should be tried. The result in one case was to restore animation for the time; and where recovery was possible, more permanent results may be expected.—*Am. Med. Digest*.

**RESECTION OF THE CLAVICLE FOR SARCOMA.**—An interesting surgical case has been placed on record by M. Polaillon. The patient was a girl aged sixteen, in whom a swelling of the outer end of the right clavicle was first noticed eighteen months ago, and had gradually increased in size. There was not much interference with the movements of the arm, and but little pain. The tumour was about the size of the fist, of bony consistence, and lobulated in outline. The skin over it was normal. There were no signs of compression of the brachial nerves or vessels. The lymphatic glands were healthy. Careful examination showed that the tumour did not pass beyond the limits of the expanded clavicle in any direction. The operation was performed on Jan. 29th under the spray. A horse-shoe shaped incision was made through the soft tissues, and the flap turned inwards, its base being at the neck of the patient; the clavicle was cut through at the insertion of the sterno-mastoid in the inner third of the bone, and then disarticulated at its outer extremity. In order to isolate the tumour the fibres of the trapezius and deltoid were cut through at their insertion into the clavicle. Antiseptic dressings were applied. The patient did well, and left the hospital six weeks after the operation. There was but little deformity, and the movements of the arm were perfectly preserved.—*London Lancet*.

**THE TREATMENT OF ASTHMA.**—According to Dr. Rodet, the best means of overcoming a paroxysm of asthma consists in subcutaneous injections of morphia and inhalations of iodide of ethyl. Twelve drops of the latter, poured on a handkerchief and inhaled, procure almost immediate relief. The different papers and cigarettes which have been recommended are worthy of a trial, a change of air and occupation is often essential. In catarrhal asthma, the treatment must be directed against the bronchitis and laryngitis, which are often benefited by a stay in a warm climate. According to M. Hardy, very good results are sometimes obtained by means of a blister applied to the thighs or arm. In nervous asthma, bromide and iodide of potassium are the most useful remedies, especially the latter. Gymnastics and baths of compressed air can also be recommended.—*Journal de Medecine de Paris*, No. 25, 1884.

**THE AFTER-TREATMENT OF SCARLET FEVER.**—Mr. George Smith, of Somerset, England, in a

short note on this subject in a recent number of the *Bristol Medico-Chirurgical Journal*, gives a plan of treatment of the desquamative stage of scarlet fever which has been quite successful in his hands, and which might be followed with good prophylactic results in every case. It is well known that in this stage there is very great danger that the disease may be conveyed from a patient to a healthy person, even several hundred miles away.

To obviate this danger, he has been in the habit for several years of having his patients sponged over the whole surface of the body twice daily. The sponging is begun, as a rule, about a week after the appearance of the eruption, and is continued until the desquamative stage is completed. The material with which the patient is sponged is a mixture of one ounce of oatmeal to one pint of boiling water; this solution should be made fresh each day, and used while tepid, or at such a temperature as may be comfortably borne by the back of the hand. The gluten of the oatmeal sticks the scales of the skin to one another and to the surface of the body, which allows of their removal without the usual risk of infecting the atmosphere or clothing; thus greatly lessening the risks of spreading the disease. The gluten also fills the cracks in the new skin and protects it from the cold; which diminishes the risk of the oedema which so frequently follows scarlatina.—*Am. Med. Association Journal*.

**NAPHTHOL FOR ITCH.**—Prof. Hardy publishes the following formula in the *Union Medicale*: Naphthol, 10 parts; vaseline, 100 parts. The powdered naphthol is to be dissolved in half its weight of ether. This solution is to be mixed with a portion of vaseline, and heated to 30° or 40° C., until the ether has been entirely evaporated, when the rest of the vaseline is to be added, and the mass carefully triturated. The homogeneous ointment thus obtained is to be kept from the access of air. It may be applied at any stage of itch, and whether it is or is not complicated with other eruptions. The duration of the treatment varies from 10 to 15 days.—*Med. and Surg. Reporter*.

**A NEW TREATMENT OF EPITHELIAL CANCER.**—Experiments now in progress, under the supervision of Dr. J. E. Garretson, at the Oral Hospital of this city, show a wonderful curative value in the treatment of epithelial cancer with the use of epiderm secured from the horse by means of a curry-comb, the treatment being nothing more complex than keeping a sore continuously covered with the ash-colored powder thus obtained. The horses are to be washed over night and curried with new curry-comb in the morning. After pick-out the hairs the powder is ready for use. When horse epidermis is not to be obtained, the scales may be scraped by means of a knife-blade from the human arm or leg.—*Med. and Surg. Reporter*.

**STRICTURE.**—In urinary obstruction, due to prostatic hypertrophy or thickening of the mucous membrane of the urethra, Professor A. B. Palmer says that relief can frequently be obtained, and the evils of catheterization avoided, by simply making the stream of urine act as a hydrostatic dilator in its passage. This can be readily done during micturition by compressing the urethra between the thumb and fingers so that no urine can escape. An effort is to be made at the same time to forcibly empty the bladder. The result is that the urethra is gently and uniformly distended without pain. This distension can be obtained and sustained at will, and in a majority of cases, if daily repeated, will soon be followed by the power of almost completely emptying the bladder, with a fair and often a full stream.—*Medical Bulletin*.

**JABORANDI IN OBSTINATE HICCUGH.**—Pagensteher (*Ctrbl. f. d. ges. Therap.; Bull. gén. de Therap.*) reports a case of hiccough which had resisted every known remedy, including the bromides, morphine, chloroform, and electricity. The patient's diaphragm contracted in the most violent manner about twenty or thirty times a minute, and he had been unable to take any nourishment for three days. After receiving four grains of jaborandi-leaves, in the form of a decoction, he had a profuse perspiration, after which the hiccough was completely checked.—*New York Med. Jour.*

To render blood more coagulable—when we have effusions of the same into cavities and so cannot ligate the bleeding orifices, Prof. Gross advises—

R.	Acid. gallici.	gr. ij
	Digitalis foliorum,	
	Ergotin.,	aa gr. j
	Opii,	gr. ss. M.
SIG.	—Ter die.	

When the stomach is irritable, so that medicines cannot be retained, and if it should be necessary to purge the patient, Prof. Gross recommends the following injection, should there also be much tympany: Oil of turpentine, ʒss, rubbed up with the yolk of one egg, then add castor oil, ʒiiss, warm water, Oj. To be used as an injection.—*Col. and Clin. Record*.

**PRURITIS ANI** and the distressing itching of urticaria and mosquito bites can be much alleviated by local applications of methol. It may be used by rubbing the methol pencil lightly over the surface, or by dissolving a small amount in alcohol and bathing the part.—*Lancet and Clinic*.

**LITTLE BOY:** "Please I want the doctor to come and see mother." **Servant:** "Doctor's out. Where do you come from?" **Little Boy:** "What! Don't you know me? Why, we deal with you. We had a baby from here last week!"

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

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## THE AMERICAN MEDICAL ASSOCIATION

The thirty-sixth annual meeting of the American Medical Association was held in New Orleans April 28th and following days, under the presidency of Dr. Campbell, of Augusta, Ga. Although the attendance was not as large as was anticipated, the meeting was, upon the whole, a very interesting and profitable one. The address of the learned President was an able effort, and was listened to with profound attention. He referred to the honor conferred on the State he represented, and eulogized the long list of illustrious men who had guided the destinies of the Association, making special reference to Gross, Sims and others. He also paid a high compliment to Dr. N. S. Davis, of Chicago, who is generally regarded as the father of the Association, and who has faithfully watched over its interests for many years. He also alluded to the assured and satisfactory success of the *Journal of the Association*. He next referred to medical politics, so to speak, such as forensic medicine, the medical witness, the medical expert, etc., and suggested that a new Section should be formed, to which all papers, questions and reports in regard to the relations of medical men to legal tribunals might be referred.

The address on medicine was delivered by the chairman, Dr. Didama, of Syracuse, N. Y. Instead of giving a summary of the progress of this department during the past year, as is

required by the by-laws, he alluded to two topics merely as having acquired special prominence, viz: the comma bacillus and cocaine. In speaking of the relation of the former to cholera he made a remark which we are sure all will endorse, "The results of Koch's experiments were negative so far as treatment was concerned, but let us labor and wait, and in the meantime direct a little more attention toward prophylaxis and therapeutics." The subject of the address on obstetrics by the chairman, Dr. Sutton, of Pittsburg, Pa., was "The History of Ovariectomy." This address is published in the present issue of the LANCET, and will be found very interesting and instructive reading.

The presentation of the report of the Committee appointed last year to make arrangements for the forthcoming meeting of the International Medical Congress in 1887, occasioned some lively discussion. The objections urged were that several "new code" men had been appointed to important positions as officers of the Congress and its sections, and that several States and Territories in the South and West were entirely unrepresented. The result was the appointment of thirty-eight additional members to the original Committee, with power to revise and correct the list of officers previously announced. It is to be hoped that the action of this monster committee will not jeopardize the success of the Congress. The *Boston Med. and Surgical Journal* in commenting on the action of the association says that the Congress is "more interested in medical science in the abstract than in local medical politics," and "that the "new code" nonsense had best be allowed to pass into ready oblivion, and not be given fictitious importance by further discussion."

The report of the committee on publication showed that the "Journal" was free from debt, had about 4,000 subscribers and promised soon to be the foremost in the United States. Dr. Davis of Chicago, was unanimously requested to continue as Editor. The social side of the meeting was all that could be desired. The members enjoyed the generous hospitality of their chivalrous brethren in the South to the full. His many friends in Canada will be pleased to learn that Dr. Brodie of Detroit, has been chosen president for the ensuing year. The next meeting will be held in St. Louis, on the first Tuesday in May 1886.

### MISDIRECTED UTERINE EFFORT.

Every experienced accoucheur has met cases of misdirected uterine expulsive force. Two recent cases of this nature which have come under our observation, are the occasion of the following remarks. In both cases the women had borne several children. Labor in each case had always been both protracted and severe, continuing from twenty-four to forty-eight hours. Medical aid had invariably been called. In both cases, on arrival, the os was found fully dilated. The presentation was normal, and the head engaging the upper strait. The pelvis, in each case, was roomy and offered no unnatural obstruction. The pains were severe and attended with strong expulsive effort—in fact, of the character which usually marks the termination of a severe case of labor. A casual survey of the situation might easily have led to the prediction of a speedy delivery. A little waiting and a more critical examination, however, exhibited things in a different light. It soon became apparent that, notwithstanding the powerful uterine contractions, and the consequent suffering, little or no advance was made. From this it was evident that something was wrong. Placing the hand on the abdomen during the partial interval of pain, it was found to be prominent, and conical in shape, the apex pointing diagonally over the pubes. During a pain, this cone, with the hand resting on it, was carried forward over and beyond the pubic arch, thus doubling the fœtus upon itself, and showing that more force was directed to this point than to the outlet. Every obstetrician occasionally meets a case of which the above is more or less typical. The os is either dilated or dilatable; the presentation normal; the pelvis roomy, and the soft parts offering no apparent obstruction; the pains are severe, and the patient makes powerful expulsive efforts. All this, and yet hours of patient waiting and suffering are marked by no perceptible progress. The unfortunate woman is in great agony, and nature is fast becoming exhausted. Friends are in despair, and demand that “something” be done. The situation is a trying one to all concerned. Of course these remarks apply more or less forcibly to all cases of protracted labor irrespective of cause.

Having discovered the cause of delay, the next thing to do is to find and apply a remedy. Chlo-

roform, morphia, and chloral, as everybody knows, are all agents well fitted to relieve the suffering and also to promote normal uterine contraction, where there is a deviation from this condition. In the cases under notice, chloral was the agent selected. About twenty grains were administered the first dose, and ten grains at regular intervals afterwards. A sheet was folded to the width of an ordinary abdominal bandage. This was passed under the patient, and crossed over the abdomen. The upper end was handed to the nurse, sitting at the opposite side of the couch, while the lower end, which embraced the cone, was held by the accoucheur. The nurse was directed to make no traction, but simply to retain a firm hold. The force exercised consisted mainly in *resisting* the downward and forward movement of the prominent uterine segment or cone. The pains, which had been insufferable, and without distinct interval, became more tolerable, having intervals so well marked as to permit quiet and needed sleep. The woman, who a little while before was in the utmost agony and despair, was now quiet and hopeful, and thus the case rapidly progressed to a happy termination. In each case the duration of labor was reduced to less than one-third that of former labors.

These cases are not presented on account of anything striking or novel, nor yet on account of the line of management pursued. The object rather is to put the profession in remembrance of the great fact that much can be done to shorten the duration of labor and to relieve the pangs of maternity. These surely are objects worthy the attention of every physician endowed with proper feelings, and no apology should be deemed necessary for even a frequent reference to them.

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### FOOD FOR INFANTS.

The many predictions concerning the possible advent of cholera during the present summer, are receiving due attention from medical men and boards of health in our large cities, and the result of such attention cannot fail to prove highly beneficial to the public health. But should we have a very hot summer, as is not improbable, there will be the usual “Slaughter of the innocents,” in the large cities, and we think it important that the attention of the profession should be called to the

fact that three-fourths of the cases of sporadic infantile cholera are initiated by carelessness in the selection of the food given to bottle-fed infants. If from the first of June to the first of October every mother would see to it that her infant was fed with easily digested and in every respect suitable food for hot weather, we believe we should have to record at the close of this much dreaded summer a decrease instead of an increase in infant mortality.

Dr. H. Von Ziemssen, writing on *Sporadic Cholera*, in Vol. vii. of the *Cyclopedia of Medicine*, says:—"Regulation of the diet constitutes in fact the principal method of treatment of sporadic cholera and particularly cholera infantum. When mothers' milk is insufficient Liebig's Food or Nestle's Lacteous Farina are *alone to be recommended*. The latter is *especially* commendable because the physiological relations of the infantile digestive organs, particularly the lack of notable salivary and pancreatic secretions are taken into account in this fabrication, the starch contained in it having been transformed into dextrine." It should also be borne in mind that infant foods are also well adapted to the nourishment of invalids of all ages.

#### RAREFIED AIR IN PHTHISIS.

Experiments have been made from time to time in order to determine the effects of rarefied air upon respiration. The results generally show that an elevation sufficiently great to cause a diminution of the barometric pressure to one-third of its normal value is necessary to produce the desired effect upon the respiration, viz: to render it more frequent and profound. Experiments have been made with dogs by subjecting them to great variation of air pressure; but no change in the respiration was observed until a height was reached which showed considerable rarefaction of the air. It would thus seem that the influence of mountain air on the respiratory apparatus, which some physicians covet for their consumptive patients, is not very decided until heights of at least 5,000 or 6,000 feet are reached. An interesting result obtained by these experiments was that at very low pressures (about ten inches of mercury) the ultimate effect was a diminished nutrition of the tissues.

The results are of value in determining the curative properties of mountain air upon weak and

diseased lungs. But they are far from conclusive. Similar experiments were made in 1880 by Dr. Marcet with himself and a scientific companion at Courmayeur (3,945 feet) and the Col du Géant (11,030 feet high). In ascending from Yvoire to Courmayeur—a vertical distance of only 2,715 feet—the relative atmospheric humidity was lowered by 31 per cent. for the higher station, and the mean weight of the carbonic acid expired by the two experimenters was found to be in excess at the higher station over the lower by more than 8 per cent. This clearly shows the influence of even moderate altitude above sea level, coupled with increased atmospheric dryness, towards promoting combustion in the human body. At the high station of the Col du Géant, over 11,000 feet, the rate of breathing was accelerated by more than 39 per cent. in Dr. Marcet's case, and over 25 per cent. in his companion's. Although in the rarefied air of high levels the body makes more carbonic acid, it exhales it much more rapidly than under the lower pressure of the plains, and the augmented activity of the respiratory organs necessitated by breathing rarefied air is in many cases the chief curative agency of mountain districts.

ONTARIO MEDICAL ASSOCIATION.—The Association is to be congratulated on the large number of papers promised for the meeting in London on the 3rd and 4th inst. In fact it will scarcely be possible to get through with them in two days. In addition to the special subjects in medicine, surgery and obstetrics referred to in our last issue, the following papers are announced: Drs. Buck—"Sanity;" Bray—"Cæsarian Section;" Edwards—"Placenta Previa;" Beemer—"Brain Exhaustion;" Waugh—"Infantile Paralysis;" Fraser—"Continued Fevers;" Penwarden—"——"; Graham—"Mitral Stenosis;" Groves—"Urinary Calculi;" Arnott—"Diet in Disease;" Campbell—"Locomotor Ataxia;" Ovens—"Trifacial Neuralgia;" McKechnie—"Pericarditis;" McLay—"Cystitis;" Harrison—"Foreign Bodies in Larynx;" Aylesworth—"——"; Moorhouse—"The Germ Theory with specimens;" Worthington—"Lingual Neuralgia;" Duncan—"Warburg's Tincture in Canadian Practice;" Murray—"Uterine Hemorrhage after Abortion;" White—"Straight Splint in Treatment of Fractured Elbow of Childhood;"



Howe—"Effects of Cocaine on the Eye" and "The Blindness of Pregnancy;" Atherton—"Intestinal Obstruction;" Thorburn—"Passive Motion in after-treatment of Fractures;" Oldright—"Pathological Specimens;" Adam H. Wright—"Treatment of Abortion;" Yeomans—"Comp. Fracture of the Patella;" McPhedran—"Lymphadenoma" (Hodgkin's Disease); Henderson—"Pulmonary Cavities;" Dupuis—"Multiple Abscess of Liver.

In addition to the numerous papers a "Question Drawer" is to be instituted, in which members may place any question coming within the sphere of the Association. This will be opened and the questions read by the Secretary each afternoon and evening session and submitted for discussion. We hear that quite a number of our *confrères* from Montreal, Buffalo, and Detroit are invited and will be present.

**IODINE IN THE TREATMENT OF GOITRE.**—The injection of iodine into the thyroid body for the cure of goitre seems to be very generally practiced by leading surgeons, with much greater success than the treatment by excision. The only danger in the former plan is that of sudden death, which, although it rarely occurs, is extremely serious. As compared with excision the danger is trifling, hence it is much more preferable, provided it is curative. The safest place to make the punctures is, on either side, between the jugular vein and the sterno-mastoid muscle. The injections should not be confined to one spot; and should be repeated about once a week for several months. The following mode of injecting is recommended by Dr. W. J. Tivy, in the *British Medical Journal*:

"Having drawn up from thirty to sixty minims of tincture of iodine into the syringe, before screwing on the needle, adjust the needle to the syringe, and force a few drops of the iodine in the syringe through the needle so as to effectually expel all air from the needle itself; and having well oiled it with carbolic oil (one in twenty), push the needle to the depth of about an inch well into the goitre, and, raising the syringe higher than the point of puncture, so as to avoid injecting air, should any remain in the syringe, slowly inject the iodine when this has been done, rapidly withdraw the needle, pinching up the skin around it to prevent any escape of the iodine."

The iodine treatment by injecting goitrous hypertrophy is one that requires time, patience and perseverance to accomplish a cure; but it is much safer than extirpation, and it is evidently superior to treatment by the application of iodine externally and iodide of potassium internally.

**HEART BEATS.**—Dr. W. B. Richardson of London, says he was recently able to convey a considerable amount of conviction to an intelligent scholar by a simple experiment. The scholar was singing the praises of the "ruddy bumper," and saying he could not get through the day without it, when Dr. Richardson said to him: "'Will you be good enough to feel my pulse as I stand here?'" He did so. I said: 'Count it carefully; what does it say?' 'Your pulse says 74.' I then sat down in a chair and asked him to count it again. He did so, and said: 'Your pulse has gone down to 70.' I then lay down on the lounge, and said: 'Will you take it again?' He replied: 'Why, it is only 64; what an extraordinary thing!' I then said: 'When you lie down at night, that is the way nature gives your heart rest. You know nothing about it, but that beating organ is resting to that extent; and if you reckon it up it is a great deal of rest, because in lying down the heart is doing ten strokes less a minute. Multiply that by sixty, and it is 600; multiply it by eight hours, and within a fraction it is 5,000 strokes different; and as the heart is throwing six ounces of blood at every stroke, it makes a difference of 30,000 ounces of lifting during the night. When I lie down at night without any alcohol, that is the rest my heart gets. But when you take your wine or grog you do not allow that rest, for the influence of the alcohol is to increase the number of strokes, and instead of getting this rest you put on something like 15,000 extra strokes, and the result is you rise up very seedy and unfit for the next day's work till you have taken a little more of the 'ruddy bumper,' which you say is the soul of man below."

**POTT'S DISEASE IN YOUNG CHILDREN.**—As a substitute for the plaster-of-Paris jacket Dr. H. C. Wyman, of Detroit, has devised a method of treatment which presents many commendable features. It is substantially a moveable jacket, and its application is as follows: The child being placed in such position that the spine is extended to nearly the normal limit; a piece of canton flannel large

enough to cover, say one-third of the circumference of the trunk, is laid on the back. A sheet of absorbent cotton having been placed over this, a cheese-cloth bandage six inches wide and several yards long, with the meshes carefully filled with plaster-of-Paris, is dipped in water and folded length-wise over the whole. When rubbed smooth with the hand so that it is perfectly adapted to the contour of the parts, a bandage is applied around the trunk, with figure-of-eight turns about the shoulders and pelvis, and the plaster allowed to set. The jacket thus constructed is in the form of a splint, and can be removed every night for the purpose of permitting massage.

**MEDICAL COUNCIL ELECTION.**—The following are the names of the newly elected members of the Ontario Medical Council:

**Territorial Representatives.**—Drs. J. L. Bray, Western and St. Clair; E. G. Edwards, Malahide and Tecumseth; R. Douglas, Saugeen and Brock; J. A. Williams, Gore and Thames; J. Russell, Burlington and Home; J. H. Burns, Midland and York; R. B. Orr, King's and Queen's; A. Ruttan, Newcastle and Trent; H. W. Day, Quinte and Cataraqui; J. G. Cranston, Bathurst and Rideau; D. Bergin, St. Lawrence and Eastern; ———, Erie and Niagara.

**Collegiate Representatives.**—Drs. J. W. Rosebrugh, University of Victoria College; V. H. Moore, Queen's College; W. T. Harris, Trinity College; H. H. Wright, Toronto School of Medicine; F. Fowler, Royal Col. Phys. and Surgs., Kingston; W. B. Geikie, Trinity Medical School; A. G. Fenwick, Western Univ., London.

**Homœopathic Representatives.**—Drs. Geo. Logan, G. Henderson, C. T. Campbell, E. Vernon, G. E. Husband.

**PERSONAL.**—Dr. D. J. Grant, of Woodbridge, Ont., on the eve of his removal from the village, was presented with a beautifully engraved silver water pitcher, and Mrs. Grant with a massive silver salver, with suitable inscriptions. An address expressive of the high esteem in which both the Dr. and Mrs. Grant were held by the citizens, and best wishes for their future prosperity and happiness, accompanied the presentation. Many of the leading citizens were present, and all spoke in flattering terms of the Doctor's sterling qualities and of his successful public and professional career. We

heartily endorse the action and sentiments of his many friends in Woodbridge, and trust that he may be long spared to be a blessing to those among whom he may minister in the future.

**TORONTO UNIVERSITY CONVOCATION.**—The following gentlemen received the degree of M. B. in this University. J. H. Howell, *Gold Medallist*; L. Cars, M. R. Saunders, H. N. Hoople, *Silver Medallists*; C. H. Britton, F. W. Cane, J. D. Courtney, W. J. Greig, A. B. Kinsley, C. A. Krick, D. J. Minchin, D. Poole, M. Staebler, A. S. Thompson.

M. D., J. Bray.

**SCHOLARSHIPS.**—*First Year*, S. Cummings and J. A. Palmer. *Second Year*, F. P. Bremner and A. Ego. *Third Year*, A. W. Bigelow and G. A. Peters.

**TRINITY UNIVERSITY.**—The following is a correct list of the successful candidates in the primary examination:—J. R. Logan, H. H. Hawley, John McLurg, James McLurg, J. H. Hamilton, W. R. Nichols, J. M. Thompson, D. McLaughlin, A. E. Yelland, T. F. Campbell, C. R. Staples, J. E. Midgeley, B. Hawke (*Honors*), T. G. Lundy, W. J. Stevenson, W. Giles, H. C. Phillips, G. S. Pater-son, J. H. Hoover, O. J. Niemeire, F. E. Luke, J. A. Tuck, C. E. Thompson, J. C. Moffatt, D. Mc-Edwards, J. W. Hart, T. S. Philp, T. Primmer, W. F. Graham, W. Ianson, M. Maxwell, A. E. Mac-kay, J. P. Shaw, D. A. Kidd, H. R. McCullough, W. A. Fish, D. M. Gordon, J. J. Soden, C. A. Toole, D. S. Thompson, J. C. C. Grasett, S. H. Irwin, D. Kester, H. Blair, J. W. Shillington, T. Wilson, G. Gordon, S. T. Bell, R. A. Barber, H. S. Bingham, H. J. Caldwell, J. G. White.

**BISHOP'S MEDICAL COLLEGE, MONTREAL.**—The following gentlemen have passed their examination in this University:—M.D., C.M.—F. R. England, "*Wood*" and "*Nelson*" *Gold Medallist*; J. B. Saunders, *Chancellor's Prize*; C. E. Parent, C. R. Gillard.

**PRIMARY.**—A. F. Longway, *David Scholarship*; T. J. Groulx, *Practical Anatomy Prize*; R. Campbell, A. P. Scott.

**CORROSIVE SUBLIMATE IN CATARRH.**—Bichloride of mercury, in a solution of one grain to the pint of water, to which two ounces of cherry laurel may be

added, is recommended in the treatment of inflammatory conditions of the nose and throat, with profuse muco-purulent secretion. Crusts that may be present and tenacious mucus should be removed from the surfaces, which should then be sprayed with an atomizer provided with suitable tubes. Dr. J. N. Mackenzie regards it as a most valuable disinfectant in ozæna and fœtor of the breath from pharyngeal disease. He found it successful in his own case in abating an acute coryza, and had good results in treating chronic nasal catarrh.

**NEW YORK POLYCLINIC.**—The Winter Session of the New York Polyclinic ended on Saturday, May 30th. The number of physicians who have attended the clinics since Sept. 22nd, is over 200. The Summer Session opens Monday June 1st, and will continue to Sept. 12th. The following clinics will be held each week: Gynæcology 12, Disease of Children 6, Surgery 8, Diseases of the Skin 6, Diseases of the Chest, General Medicine and Diagnosis 6, Diseases of the Eye 6, Diseases of the Throat, Nose and Ear 6, total 50. In addition Obstetric cases will be given to the class and a course in urinary analysis. The Laboratory of Pathological Histology will be open all Summer.

**ATROPINE IN EPILEPSY.**—David ("Lyon méd.") *N. Y. Med. Jour.*, administers to epileptic patients twenty grains of bromide of ammonium, and at the same time gives fifteen thousandths of a grain of sulphate of atropine night and morning. After this treatment has been continued for six months, he directs that two of the following pills be taken daily for at least a year:

Valerianate of zinc	.....	$\frac{3}{4}$ grain;
Extract of belladonna	.....	$\frac{1}{10}$ "
Arsenious acid	.....	$\frac{3}{10}$ "
Extract of gentian	.....	q. s.

**TONIC AND DIURETIC.**—The following has been highly recommended in anasarca and other affections demanding similar treatment:

R Ferri sulph.	. . .	3i.
Pot. acetat.	. . .	3ij.
Sq. scillæ.	. . .	3ss.
Ext. digitalis fld.	. . .	3i.
Spt. juniper, co.	ad	3viii—M.

Sig. A tablespoonful in a little sweetened water three times a day.

**PNEUMOTHORAX FOR HÆMOPTYSIS.**—At a meeting of the Clinical Society of London, Dr. Cayley, reported a case of hæmoptysis treated by producing pneumothorax (*Lancet*, May 16th.) The patient was much reduced by repeated bleeding, and it was determined to admit air into the pleural cavity with the view of exercising atmospheric pressure and diminishing the circulation through the collapsed lung. The hæmorrhage was arrested, but the patient was too much reduced, and died of syncope, on the fifth day after the operation.

**UNIQUE CASES.**—Dr. Belfry of London, Ont., reports the case of a child which weighed 18½ lbs. at birth, and measured 23¾ inches in length. He also reports the case of a woman 42 years of age, now at the menopause, who is cutting two new incisor teeth. Her permanent incisors decayed and were extracted last year. She is a weakly woman; had a tumor removed from the abdomen 15 years ago in Manchester, England, and a discharging sinus has continued ever since. She is also suffering from caries of the os innominatum. Both cases are unusual if not unique.

**MELLIN'S FOOD.**—Among infant foods which have become popular with the profession may be mentioned Mellin's Food. The manufacturers, Messrs. Doliber, Goodale & Co., of Boston, are to be congratulated on the recognition of their exhibit of this Food at the New Orleans exhibition, the judges awarding it the first prize, a gold medal, as the best food for infants and invalids.

**CHOLERA INOCULATION.**—It is reported that between four and five thousand persons in Valencia, Spain, have been inoculated with cholera microbes by Dr Ferràn. The results are said to have been successful, and the epidemic is disappearing. A commission has been appointed by the British Government to investigate Dr. Ferràn's experiments.

**INTOLERANCE OF POTASSIUM IODIDE.**—Many persons are entirely unable to take even very small doses of iodide of potassium, without producing unpleasant effects. To overcome this it is recommended to combine with it ordinary doses of fluid extract of belladonna. The addition of a small quantity of fluid extract of liquorice will also cover the taste and render the mixture more palatable.

**CROTON CHORAL HYDRATE.**—This remedy, for-

merly so much relied upon in the treatment of painful affections of the 5th nerve, is now much used in the treatment of neuralgic dysmenorrhœa, sciatica, lumbago, etc. Five or six grains in glycerine and water may be given three times a day.

**VOMITING OF PREGNANCY.**—The application of ether spray over the epigastrium is recommended in the vomiting of pregnancy. Immediate benefit has been derived from its use where drugs of all kinds have failed to afford relief.

**CORRECTION.**—In our April issue, page 239, the address of J. Ellwood Lee, manufacturer of Levis' Splints, was incorrectly given. It should have been 425 Walnut St., Philadelphia.

**TRINITY MEDICAL SCHOOL.**—The Fellowship Diploma of Trinity Medical School has been formally recognized by the Royal College of Physicians, London, Eng., and also by the "Triple" Examining Board of Edinburgh. This Diploma is now recognized by all the licensing bodies in Great Britain.

The death of Prof. Henle, of Berlin, the celebrated anatomist and physiologist, on the 18th ult. at the advanced age of 74 years, is announced. Also Prof. Panum of Copenhagen.

**CORONER.**—Dr. G. H. Bowen, of Seeley's Bay, Ont., has been appointed Coroner for the Counties of Leeds and Grenville.

We regret to announce the death of Mrs. Dr. Workman of this city, at the age of 72 years.

This estimable lady sustained the sacred and endearing relationship of wife and mother, for nearly half a century, and embellished a life devoted to its duties with all the graces of the Christian character. Dr. Workman has our deepest sympathy in his great bereavement.

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### Books and Pamphlets.

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**INHALATION TREATMENT OF DISEASES OF THE ORGANS OF RESPIRATION.** By Arthur Hill Hassall, M.D., Lond. Longman & Green, London. Hart & Co., Toronto.

Dr. Hassall of San Remo, in the Western Riviera, has in the above volume furnished the profes-

sion with a succinct, but sufficiently exhaustive notice of the various requisites to be fulfilled by the very numerous forms of Inhalers that have from time to time been placed in the market, as also of the adaptability of the inhalation treatment for certain diseases of the organs of respiration. The subject is treated in seven chapters under the following heads: 1. Entrance of medicaments into the organs of respiration. 2. Principles concerned in the volatilization and inhalation of the medicaments. 3. The apparatus to be employed. 4. Inhalation chambers. 5. The quantities of the medicaments, the manner, frequency and duration of the inhalations. 6. The medicaments employed in inhalation. 7. The various diseases in which benefit may be expected to be derived from this mode of treatment. At the Continental spas it would seem to be the practise to make extensive use of inhalation chambers, the apparatus for which the author describes as also the various substances used for sprays and vapors, in which chambers the patients will remain for hours, breathing the artificial atmospheres. The work is a valuable addition to the literature on the subject

**A PRACTICAL TREATISE ON DISEASES OF THE EAR.** By D. B. St. John Roosa, M.D., LL.D., Prof. of Diseases of the Eye and Ear, New York Post-Graduate Medical School, and President of the Faculty; Surgeon to the Manhattan Eye and Ear Hospital. New York: Wm. Wood & Co. Toronto: Williamson and Co.

We are pleased to receive the sixth edition of this standard work on the ear. The author is well known as a specialist on the ear, and the previous editions of his work have been greatly appreciated by the profession. The edition before us has been revised with great care, new matter has been added and the work contains much information of value to the general practitioner. We have great pleasure in recommending this book to our many readers, as a reliable guide to the diagnosis and treatment of affections of the ear.

**A GUIDE TO THE DISEASES OF CHILDREN.** By James F. Goodhart, M.D., F.R.C.P., Assistant Physician to Guy's Hospital. Philadelphia: P. Blakiston, Son & Co. Toronto: Hart & Co.

The scope of this work may be defined by the following extract from the author's preface: "I have not considered it my function to write a book on general medicine, but so far as possible, I have kept in view the diseases which seemed to be incidental to childhood, or such points in disease as appear to be so peculiar to, or pronounced in chil-

dren as to justify insistence upon them." In the second chapter will be found valuable hints for the young practitioner on the diet of children in health, as also in the third chapter for the treatment of derangements arising from faulty diet. The fourth treats on acute and chronic diarrhoea. The author impresses on the reader the importance of never missing an opportunity of examining the alvine evacuations, as the appearances will give valuable suggestions for treatment. The fifth treats on stomatitis, thrush, cancrum oris. The sixth on diseases of the digestive tract. The remaining chapters, forty-eight in all, deal with the various diseases of infancy and childhood in a manner at once interesting and instructive. Unqualified admiration must be expressed for the ability exhibited in arrangement, and for the clear and attractive form in which the author has placed his views before the reader.

THE ANNUAL AND SEASONAL MAPS OF THE UNITED STATES, by Prof. C. Denison, M.D., Denver, Colorado. Chicago: Rand, McNally & Co. Size of map 58 x 41. Price, mounted on muslin, \$5 00: on thick paper, \$3.00.

These maps illustrate the climate, temperature, humidity, cloudings, direction of winds, and physical features of the country. They will be found invaluable to physicians and others who have occasion to recommend or take advantage of change of climate. All the mineral springs and health stations in the United States are also referred to in the tables. We recommend these maps to the attention of the profession in Canada.

MEDICAL BOTANY OF NORTH AMERICA. By Lawrence Johnson, A.M., M.D. New York: Wm. Wood & Co. Toronto: Hart & Co.

The above-named work is a valuable addition to Wood's Standard Library of Medical Authors. As the title indicates the book treats principally of the botany of the plants whose therapeutic activity has placed them in the various text-books on *Materia Medica*. The work is illustrated with well executed coloured plates and wood cuts, and supplies a hitherto existing want, viz., a good manual on medical botany.

### New Instruments.

#### COMBINED RECTAL AND INTRA-UTERINE IRRIGATOR.

Dr. J. S. Coleman, of Augusta, Geo., describes the following instrument in the *Brit. Med. Journal*, April 18th, '85:—In the *Medical Record* of New York, for May 10th, 1879, I presented to the medical profession the "Metro-clyst." I now desire

to call attention to a modification of this instrument, which makes it available for the diseases of the rectum and surrounding pelvic structures. The instrument is of hard rubber, and consists of a cylindrical frame or cage traversed by a central tube. This arrangement insures the easy exit of the injected fluid. Any ordinary syringe can, by means of rubber tubing, be attached to it. My preference in the use of hot water is for the siphon. Thanks to the genius of Dr. T. A. Emmett, we all now appreciate the indispensable value of hot water, in inflammation and as an hæmostatic. Though I have not yet had an opportunity of test-



ing the merits of this instrument in ovaritis, pelvic cellulitis, or peritonitis, I feel confident that we will find it one of our most efficient measures in combating these serious and obstinate forms of disease. So far as I am informed, Dr. J. R. Chadwick was the first to advocate the rectal use of hot water in the treatment of pelvic inflammations (*vide* his able and interesting paper in the *Transactions* of the American Gynæcological Society for 1880). To me it promises much in acute prostatitis, inflammation of the rectum, and internal hæmorrhoidal troubles. I have had most gratifying success from its use in a case of puerperal endometritis, and in one of rectal ulcers.

### Births, Marriages and Deaths.

On April 30th, H. K. Kerr, M. D., to Anna E., eldest daughter of F. Franklin, Esq., both of Hammond, N. Y.

# THE CANADA LANCET.

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## Original Communications.

### INTRA-UTERINE MEDICATION.\*

BY J. ALGERNON TEMPLE, M.D., M.R.C.S., ENG.

Prof. of Obstetrics and Diseases of Women and Children  
Trinity Medical College, Toronto.

It is well known to all the members of this Association that we are making a departure this year from our usual custom, and that instead of reading reports on the progress of the various branches of our profession within the past year, the chairman of each section has been requested to open a discussion in his special department, by choosing some subject for consideration. As chairman of the obstetrical and gynecological department I have selected for our consideration the subject of "Intra-Uterine Medication." It is not my intention to impose upon you any lengthy paper, nor do I intend to defend, or otherwise, this special subject; but merely to relate my own experience and pronounce my own judgment on this plan of treatment in certain uterine affections and thus draw from those present, interested in the subject, their own ideas and value of the procedure. I am well aware that this plan of treatment has its adherents, but it also has its opponents. There are some excellent men on our own continent who are strongly opposed to the procedure, while again in the old world some men equally good who are just as strongly in favour of this plan of treatment, and while I greatly respect both of these classes of practitioners, yet I unquestionably belong to those who believe in the great advantages of this plan of treatment in properly selected cases. To apply this system of treatment to all and every local uterine complaint is undoubtedly hurtful; to exclude constitutional treatment and depend entirely on local

treatment is also wrong, the two plans of treatment should go hand in hand. That injurious effects have probably arisen in some cases I do not doubt, but at the same time I am disposed to attribute these bad effects to neglect of certain precautions and not to the plan of treatment itself.\* The more clearly the subject is understood and the dangers known of the indiscriminate use of this plan of treatment, the greater will be the good results. The conditions most benefited are diseases of local origin, such as we see following abortions or confinement, the condition known as subinvolution, uterine catarrh, diseased conditions of the mucous membrane of the uterus, chronic endometritis, profuse and frequent menstruation, metrorrhagia, a large and flabby and relaxed uterus, cervical hyperplasia, cervical erosions, supersensitive condition of the lining membrane of the uterus, and uterine fungosities; while tumors and polypi and conditions depending on diseases of the Fallopian tubes and ovaries are not thus to be treated. I am quite satisfied that in all these diseases constitutional treatment is of the greatest importance and must not be neglected, but still it alone will not produce a cure; it is necessary to treat the diseased uterus locally.

We come now to consider the mode of applying the remedies. For the successful application of any remedy it is necessary that the cervical canal be sufficiently patulous to allow of the easy passage of a probe, armed with cotton wool, and saturated in the remedy, to pass through into the uterine cavity. In the diseases to which I have just alluded such is generally the condition, but if not it must be dilated first. Secondly, all mucous secretion should first be carefully removed from the uterine cavity so as to enable the remedy to come into direct contact with the diseased surface. And thirdly, no uterine inflammation or tenderness in the surrounding vicinity of the uterus should exist. First remove such tenderness by leeches, scarification, hot vaginal douches and rest in bed, and gly-

\* The reason assigned by those who do not approve of applications to the uterine cavity is that the mucous membrane is being constantly removed and renewed, and hence no good will come of applications. Such might also be said of the skin. Take a case of simple chloasma, because the epidermis is being constantly renovated are we not to treat this disease by local applications. So in cases of cystitis, the same thing would be applicable, and I might multiply such instances. To my mind it is not a sufficient argument against Intra-Uterine Medication.

\*Read before the Ontario Med. Association, London, June 4th, 1885.

cerine pads, and then proceed to heat the cavity. To apply any remedy to the cavity, I think the best position for the patient is on her side with nates near to edge of the bed, then having introduced a good large sized Sim's speculum into the vagina, the os is fully exposed to view; then lay hold of the anterior lip of cervix with a pair of vulsellum forceps and draw down the parts, pass a sound gently through the canal to ascertain its exact course, cleanse out the cavity with one or more of Playfair's probes wrapped round with cotton wool (absorbent), then take another, previously bent to correspond to the cervical canal, dip it in the solution you are about to use, and pass it directly into the uterine cavity as far as the fundus uteri, turn it round several times so as to touch the whole of the interior and leave it there for a minute or more. Be careful during this part of the treatment that the surplus fluid does not run down the vagina and over the thigh, as it will cause a good deal of pain and discomfort to the patient. Unless nitric acid or some such caustic is being used, it is not necessary to use a cervical speculum or protector, for what fluid is wiped off from the probe in its passage through the cervical canal is only enough to treat this part of the uterus.

Now, as to the frequency of these applications, I think once in four or five days for the alterative and astringents is enough, once in ten to fourteen days enough for the caustic ones. After the application the patient had better, as a precautionary measure, remain quiet for a couple of hours on her bed, though I am constantly in the habit of making such applications in my own office. It is exceedingly uncommon to find any unpleasant symptoms follow such procedure; for my own part I never saw an accident occur. I know it is reported that fatal peritonitis has followed this plan of treatment, and I am inclined to attribute such an unfortunate accident to the fact that the case was badly selected, that some low inflammatory state existed and was not detected, and that the case was not a suitable one. The remedies used are not many; some recommend them in powders, some in ointment, some inject them, while others again apply them by means of a Playfair probe dipped in the desired fluid; this latter is to my mind the best. I do not like the way of injection. I once or twice used that plan but gave it up long ago on account of severe constitutional disturbance. The reme-

dies I most commonly use are carbolic acid (Calvert's No. 5), Churchill's iodine, iodized phenol, iodoform, nitric acid, and nitrate of silver. Undoubtedly many more might be added. The ones I mostly use of this list are carbolic acid and iodized phenol.

*Nitric Acid* is the strongest of them all, and should only be used for certain diseases; it is especially useful in the treatment of uterine fungosities, that sometimes obstinate disease to treat. Firstly, having dilated the cervix if requisite, and carefully scraped the whole surface of the uterus with the blunt curette, and then carefully wiped out the cavity, pass an armed probe previously dipped in the strong nitric acid through a cervical speculum into the uterine cavity. It is very necessary to use this useful little instrument so as to protect the cervical canal, otherwise sloughing and contraction might ensue subsequently. The vagina should likewise be protected by absorbent cotton dipped in a solution of carbonate of soda, so that if any acid runs out the vagina will not be injured. The application of this remedy to the uterine cavity is not painful nor have I seen any bad results ever follow its use. The patient should be kept quiet for two or three days in bed, and the remedy should not be applied again for ten or fourteen days. In the treatment of these growths I have seen the most excellent results follow; it is in fact, I think, the only condition calling for this strong caustic.

*Carbolic Acid*—This is a most useful remedy and one which I use largely. I find it especially useful in cases of uterine catarrh, and also in cases of tenderness of the inside of the uterine cavity. I am likewise in the habit of swabbing out the uterine cavity with this remedy after using the curette. Its action is slightly caustic and astringent and alterative. The preparation I am in the habit of using is Calvert's No. 5, simply because it is less caustic than the purer preparations. It causes very little pain, if any.

*Iodized Phenol*—Until I learned the good effects of this preparation, I invariably used Churchill's tincture of iodine, but of late I have quite abandoned it for this preparation. It was first introduced into practice by Dr. Battey of Georgia, and is made of one part of pure iodine to four parts of carbolic acid. This agent is particularly useful in cases of uterine hemorrhage, profuse menstruation, the result of imperfect involution, accompanied by



an unhealthy state of the lining membrane of the uterus, or in cases of menorrhagia, depending on the presence of vascular growths within the uterus. Dr. Battey likewise recommends it in malignant disease of the uterus, and Dr. Atthill speaks highly in its favor in malignant disease, for the purpose of both arresting the hemorrhage and progress of the disease; he however uses it by injecting  $\frac{3i}{4}$  of the solution once a week within the uterine cavity, and adds, no unpleasant results are likely to follow it when thus used, providing the cervical canal is patulous enough to allow the surplus fluid to flow back, and that it is injected slowly and not more than one drachm at a time. I have no experience in the use of this remedy in this form.

*Iodoform* I have used both in powder and crayons, but have not met with such good results from this remedy as to induce me to resort to it frequently.

*Nitrate of Silver*—I have introduced from five to ten grains of powdered nitrate of silver in cases of dysmenorrhœa, especially the membranous form, but it is painful and sometimes produces unpleasant symptoms, so I have abandoned it for safer and quite as good remedies.

I have thus very briefly brought before your notice this mode of treating uterine disease, and you will gather from the foregoing remarks that while I am a strong advocate for local uterine medication, I do not exclude the great advantages to be derived from general constitutional treatment, nor overlook the fact that uterine displacements, fibroid tumors and allied diseases, must receive appropriate treatment.

I do not intend that this paper should be considered in any other light than as the preliminary remarks to a general discussion on the advisability of Intra-Uterine Medication, and draw from those present an expression of opinion upon this very important subject.

### CONTINUED FEVERS.\*

BY A. S. FRASER M.D., SARNIA.

The continued fevers, which prevail at times in Western Ontario, are classified as typhoid fever, typho-malarial fever, and malarial continued fever.

In many localities, where continued fevers are

common, cases of typhoid fever which run a normal course are comparatively few in number; much more frequently this disease develops in an irregular and uncertain manner, so much so that often a case of typhoid fever will have lasted for two weeks or more before satisfactory evidence of its nature can be obtained. In consequence of this, many cases of typhoid fever are called typho-malarial fever, although this term is usually applied to cases of continued fever which have many of the characteristics of typhoid fever, yet never show any symptoms of ulceration of the bowels. The name typho-malarial fever has been applied to a form of continued fever which is supposed to be either enteric fever modified by malaria, or malarial fever which has assumed a typhoid or adynamic form from some peculiarity of the patient. There are serious objections to both these views. In the first place, in well marked cases of the so-called typho-malarial fever, there is no reason to believe that ulceration of the bowels is present at any time during the whole course of the disease, as there is no tenderness nor fulness of the abdomen, neither is there any diarrhœa nor rose spots. In other respects the fever takes much the same course as typhoid, lasting from two, to eight or nine weeks; sometimes so severe as to prove fatal early in the third week; at other times showing only a slightly elevated temperature, with little prostration, lasting for four or five weeks, with a gradual return to health at the end of that time. There is seldom much dulness of intellect, and when delirium is present it is of a more active kind than that of typhoid fever.

In the second place, the reasons for believing that this fever is not of malarial origin, are these: 1st. Paludal malaria, which is the only kind of malaria we have to take into account, is developed under pretty well known conditions, and it has always been understood that severe malarial fever is the effect either of large quantities of malaria in the neighborhood of the persons attacked, or of an unusual susceptibility on the part of such persons to the influence of this poison. In either case the source of the malaria would be further from some than others, or some persons would be so much less susceptible to its influence than others, that milder forms of malarial fever, such as intermittent and remittent, would be found in the same locality as the more serious continued fever. 2nd. This

\*Read before the Ontario Med. Association, London, June 3rd, 1885.

fever is frequently endemic when the temperature has been below the freezing point for several weeks, and the ground covered with ice and snow during that time, so that if malaria is the cause of the disease, it must have been latent in the persons attacked for some time.

Now it is a well known fact that malaria may remain latent and cause intermittent fever and other forms of malarial poisoning long after the individuals affected have been exposed to its influence; but there is no reason why such latent malaria should cause in a number of people, at about the same time, the most severe continued fever without manifesting any of its milder effects in other persons who have been living under the same conditions.

Most practitioners who have had much experience with continued fevers will agree that the so-called typho-malarial fever is difficult to separate from typhoid fever on the one hand, and malarial fever on the other. That its specific cause is probably similar to and exists under the same conditions as that of typhoid fever. Many will also concur in the opinion that typho-malarial is a term that is both inaccurate and misleading.

The following history will serve to illustrate the danger which may arise from the difficulty in separating malarial from non-malarial fevers. Waterworks were established in the Town of Sarnia in the year 1876. The supply pipe was placed in the River St. Clair, in close proximity to the outlet of a large sewer; but as the pipe extended for some distance into the channel, and the current was strong, it was not considered by those in charge of the work, that the water would be contaminated. It was noticed, however, that typhoid fever was more prevalent during the next two years than at any time before. In the spring of 1879, the supply pipe was broken by an ice jam; no attention was paid to the occurrence, and during the following summer, cases of continued fever became very numerous, many of them fatal. Unfortunately at the beginning of the outbreak the disease got the name of malarial fever. The water supply was, however, also accused of being the source of the trouble, and some samples of water, taken from the river and from hydrants in different parts of the town, were sent to Toronto for analysis. A report came back from Prof. Croft to the effect that the water was remarkably pure. This confirmed in their

opinion, those who believed that the fever was due to malaria. The water pipe was repaired and extended for a distance of a hundred and twenty feet into a channel forty-two feet deep, in which the current ran four miles an hour. The number of cases of fever did not diminish in the least, and there was no doubt that a large proportion of them were uncomplicated cases of enteric fever of a severe type. The water was again analysed more than once and declared perfectly pure. The disease continued for four years, there being constantly present in the town from four or five to forty or fifty cases. Notwithstanding the fact that competent chemists had pronounced the water pure, there were many reasons for believing that it contained the germs of fever, and the town authorities finally decided to close the sewer which emptied near the waterworks, and to direct the sewage to a point some distance further down the river. This was done and the town at once became free from continued fevers, and the disease has very seldom occurred in the place since.

Concerning malarial continued fever, it may be said to have two characteristics which distinguish it from all other forms of continued fever. 1st. It almost invariably yields to sufficient doses of good quinine. 2nd. When a person has once been attacked by this disease he is very liable to subsequent attacks, the reverse being the case in typhoid and typho malarial fevers.

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#### THE EXTERNAL APPLICATION OF SULPHIDE OF CALCIUM IN SMALLPOX.

BY J. A. M'ARTHUR, M.D., C.M., WINNIPEG, MAN.

Several years ago, Surgeon-Major C. J. Peters, of the British army of India, experimented with sulphide of calcium as an external application in smallpox, and although the cases were few in number, six, I believe, yet such were the favorable results in each and every case, that he was induced to give an account of the treatment adopted. So favorably impressed was I with the success of the treatment, that I resolved to employ it, the first opportunity that occurred.

On the 10th day of April last, I was instructed by the Provincial Government to proceed to the town of Emerson and take charge of a case of smallpox that had recently broken out in that place.

The patient was a young woman, about 23 years of age, and previous to the present attack, was in good health. The form of smallpox was the confluent—the patient never having been vaccinated—and one of the worst cases I had ever seen. The day on which I first saw her was the 9th from the initial stage of fever and 3rd of the pustular stage. The face was terribly swollen and she was unable to see. The conjunctivæ, mucous membrane of the mouth and the tongue were thickly covered with pock. The face, neck, arms and limbs as high up as the knees were literally covered, so much so, that a pin-head could not be put down without touching them, while on the backs of the hands and soles of the feet blebs as large as a half-dollar piece could be seen. There was low muttering delirium, and the symptoms present indicated extreme prostration and a speedy termination of the life of the patient.

Feeling that this was an almost hopeless case and one which would test to the utmost the merits of any remedy, I determined to apply the sulphide and watch the results. The patient's face, neck, arms to the elbows and limbs to the knees were painted twice daily. The application was made with a brush and not with a feather as recommended by Dr. Peters—the work being done much more quickly and thoroughly with the former than the latter. The third day after the application of the remedy and the 12th of the disease, the patient showed signs of improvement. The low muttering delirium passed away, the swollen features assumed their more natural and human character, while the pustules showed signs of shrinking. There was no secondary fever, and at the end of the fifth day from date of application the pustules were literally shrivelled up, without giving out any of their fluid contents. In a word the disease was aborted.

The sulphide is evidently absorbed and acts in a constitutional manner, for the pustules on the parts of the body and arms not painted, shrivelled and dried up equally as rapid as those where the application was made.

Another important feature noticed, was the entire absence of itching and desire on the part of the patient to scratch. At no time did the patient feel any desire in that direction, and the sickly, deathly exhalations, so characteristic, were scarcely perceptible. An examination of the patient's face

last week, revealed no pitting—a very important consideration. The blinds were not drawn nor the room darkened, but a flood of sun-light was permitted to enter the room, and the freest ventilation possible enjoyed. With the exception of slight ulceration of the cornea of the right eye and a slight attack of pleurisy of the right side, the patient made a rapid and successful recovery. The patient was kept on milk diet throughout, and only mild diuretics were employed as occasion required.

The liquid is prepared by boiling a quarter of a pound of quicklime and half a pound of sulphur in five imperial pints of water until the liquid is reduced to three pints, when it is filtered and kept in glass-stoppered bottles. It is applied to the affected parts two or three times a day with a brush or feather, taking care that none of it gets into the eyes.

The writer believes that the lotion acts by destroying the germs of the disease, preventing supuration, and guarding against the complications that result from blood poisoning.

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### Reports of Societies.

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#### ONTARIO MEDICAL ASSOCIATION.

The fifth annual meeting of the members of the above Association was held in London, on the 3rd and 4th ult., Dr. A. Worthington, of Clinton, President, in the chair, Dr. J. E. White, of Toronto, Secretary. The attendance was large and representative. Drs. Howe and Park, Buffalo, Drs. Jenks and Brodie, Detroit, and Dr. Stewart, Montreal, were present as delegates and invited guests.

After routine, several patients were presented for the consideration of the Association.

Dr. Pope, of Bothwell, showed a case of cerebro-spinal meningitis, in which some paralysis of the right leg, and ankylosis of the hip-joint, had followed. The President also showed a case of neuralgia of the tongue, apparently caused by carious teeth. Dr. Edwards also presented before the Association two interesting cases of myo-sclerosis, occurring in two brothers. All the cases were examined and discussed by the members present.

The President's address was next in order, and was listened to with marked attention. After thanking the Association for the honor conferred upon him, he referred to the opinion held by the

talented Sydenham, who wrote and practised from 1660 to 1680, that the six most fatal diseases prevailing in the city of London, were the plague, ague, dysentery, scurvy, child-birth, and small-pox. He was the first physician who originated the idea and carried the principle into practice, expressed in the phrase *vis medicatrix nature*, that this force in nature should be aided, nor thwarted. About the middle of the seventeenth century, or just before the time of Sydenham, the mortality of parturient women in London was about two per cent., including after consequences, while at the time these statistics were taken (1885) it was reduced to one-half per cent., and since the introduction of antiseptics into obstetric practice the mortality rate will probably be diminished to about one-fourth of one per cent. One death in every 400 may be an under-estimate of the mortality from child-birth and after consequences at the present time, but since obstetric practice has been based upon a belief in the germ theory results have been much better. He referred to the probable discoveries in scientific medicine, which they might expect to be greater in future than in the past. Ague was now almost entirely disappearing. Scurvy was likely to be little more than mentioned in the text-books of the future; and with reference to the small-pox, of which the learned and accomplished Dr. Mead, the first London physician of the day, wrote in 1747 as impossible to vanquish, vaccination was introduced in 1798, which had successfully battled with the disease. Referring to fever, the President said Boerhaave (1701 to 1731) held a theory of fever peculiarly his own, which was that the blood was the cause, the explanation being that the blood was in a thick, viscid condition, leading him to advise and insist on warm drinks being given during fevers, and that much danger was present if cold drinks were used. He (the speaker) could well remember when a child, some sixty years ago, his aunt begging for a drink of cold water, during an attack of what he presumed was typhoid fever, and was refused, the doctor saying it was dangerous to give it. To Boerhaave then must be ascribed the un. old misery of thousands who have died, famished or starved, for cold water. Most unfortunately his theory has been handed down even to the present, and it might be questioned if the idea was yet obliterated from the minds of some of the profession. He then alluded to the use of cold water affusions

in fevers by Currie, and stated that there was no question of their efficacy in scarlatina in every form. He also pointed out the fact that the use of the thermometer under the tongue and in the axilla was introduced half a century ago. In conclusion, he expressed a hope that the brief review of medical science one hundred years ago would be considered worthy of some thought, as indicating the progress which might be looked for in the next century.

There being none of the members of the Special Committee, appointed in 1884, to report on the communication from the Women's Christian Temperance Union, present, Dr. Fulton moved, seconded by Dr. Bray, that a special committee be appointed, consisting of Drs. Holmes, of Chatham; Rosebrugh, Hamilton, Geikie, Toronto; Brouse, Brockville, and the President, to bring in a report on the following morning, which was carried.

A motion expressive of condolence with Dr. Workman, in his recent bereavement, was passed, and a committee appointed to prepare a suitable memorial to be transmitted to him.

The report of the Committee on Ethics was laid over for another year.

A telegram from the Wisconsin Medical Society, in session in Milwaukee, sending greetings, was received with applause, and the Secretary was instructed to telegraph a reply expressing similar well-wishes. Dr. J. L. Bray, of Chatham, read a short paper on "Cæsarian Section," giving the history of a case in which Dr. Jenks, of Detroit, assisted him; the woman died. Dr. Jenks gave a graphic description of the operation, and stating in conclusion that he was opposed to craniotomy.

An interesting discussion on medicine was opened by Dr. Tye, of Chatham, who read an able paper on "Diphtheria." The paper and discussion will appear in the LANCET in due course, so that we shall not attempt to give any epitome.

Dr. Fraser, of Sarnia, next read a very interesting paper on "Continued Fevers."

In the evening session the Secretary read a communication from Dr. McLean, of Detroit, wishing the Society every success, and inviting the members to Port Huron at the annual session of the state medical association. The Secretary was requested to write, thanking Dr. McLean for his kind invitation.

The discussion in surgery was then opened by

Dr. Powell, of Edgar, who read an admirable paper on "Plaster Splints." The paper was discussed by the Association, after which followed an excellent paper on the "Blindness of Pregnancy," by Dr. Howe, of Buffalo, illustrated by diagrams thrown upon a screen. After a paper on "Placenta Prævia," by Dr. Edwards, of London, and another by Dr. Groves, of Fergus, on "Renal Calculi," the meeting adjourned.

On the second day, Dr. Temple, of Toronto, Chairman of the Committee on Obstetrics, opened a discussion upon "Intra-uterine Medication." Dr. Roswell Park, of Buffalo, followed with a volunteer paper on the "Surgical Sequelæ of Fevers. Many cases illustrating the various lesions coming under this head were placed for the first time on record. An important paper, written by Dr. Keen, of Philadelphia, was referred to, and much additional light thrown on a subject worthy of close observation.

At this stage it was found necessary to divide into sections in order to get the papers all before the Association. Dr. Graham, of Toronto, presided over that on Medicine, and Dr. Aikins, of the same city, over that on Surgery and Obstetrics.

Dr. Henderson, of Kingston, led off in the first section with a paper upon "Pulmonary Cavities." Drs. McDonald and Graham of Toronto, took part in the discussion, and the general opinion expressed was in the direction of sustaining the contentions of Koch, regarding the connection between bacilli and phthisis.

Dr. Duncan, of Thamesville, on "Warburg's Tincture," Dr. Ovens, of Arkona, on "Trifacial Neuralgia," and Dr. Arnott, of London, on "Diet in Disease," closed the work in this section by papers worthy of attention. A paper was also read on "Mitral Stenosis" during the afternoon by the Chairman, Dr. J. E. Graham, of Toronto.

In the Surgical and Obstetrical Section, papers were presented on "Hemorrhage after Abortion," by Dr. Murray, of Thorndale, and on "The Treatment of Abortion," by Dr. Adam Wright, of Toronto; one of characteristic vigor and originality by Dr. Harrison, of Selkirk, and one upon "Intestinal Obstruction" by Dr. Atherton, of Toronto.

Dr. Yeomans, of Mount Forest, was down for a paper on "Compound Fracture of the Patella," but unfortunately had to leave by an early train. Finally, the discussion on "Cocaine Hydrochlorate" was opened by Dr. Reeves, of Toronto, and taken

part in by Drs. Howe, of Buffalo, and Palmer, of Toronto.

The Special Committee appointed to answer the questions submitted to the Association by the Ontario W. C. T. U. presented the following report, which was adopted:

Is the beverage use of alcoholic liquors, by persons in health, beneficial? A.—No.

Is alcoholic liquor, as obtained in common sale, necessary in medical prescriptions, if so, in what cases particularly? A.—No, except in cases of emergency.

What ought to be the attitude of the medical profession towards the sale of intoxicants? A.—The medical profession is opposed to the indiscriminate sale of alcoholic liquors.

The officers elected for next year, when the Association will meet in Toronto, were: Dr. Tye, President; Drs. Arnott, Temple, Hillary, and Henderson, Vice-Presidents; Dr. White, Secretary; Dr. Graham, Treasurer; Drs. Wright, Campbell, Ayelsworth, and Mitchell, Corresponding Secretaries.

#### ONTARIO MEDICAL COUNCIL.

The annual meeting of the Ontario Medical Council was held in Toronto on the 9th ult. and following days. The following newly elected members answered to their names:—Drs. D. Bergin, Cornwall; J. L. Bray, Chatham; H. E. Buchan, Toronto; J. H. Burns, Toronto; C. T. Campbell, London; J. G. Cranston, Arnprior; H. W. Day, Trenton; R. Douglas, Port Elgin; E. G. Edwards, London; A. G. Fenwick, London; F. Fowler, Kingston; W. B. Geikie, Toronto; W. T. Harris, Brantford; G. Henderson, Strathroy; G. E. Husband, Hamilton; G. Logan, Ottawa; V. H. Moore, Brockville; Orr, Maple; Philip, Brantford; J. W. Rosebrugh, Hamilton; Russell, Binbrook; Ruttan, Napanee; E. Vernon, Hamilton; J. A. Williams, Ingersoll, H. H. Wright, Toronto, and J. A. Grant, Ottawa.

Dr. Bergin was elected President, and Dr. Douglas Vice-President of the College. Dr. W. T. Aikins was appointed Treasurer, and Dr. Pyne re-appointed Registrar.

The standing committees were appointed as follows:—

Registration—Drs. Rosebrugh, Vernon, Fenwick, and Russell.

Rules and Regulations—Drs. Day, Burns, Fowler, and Williams.

Finance—Drs. Edwards, Henderson, Douglas, Philip and Ruttan.

Printing—Drs. Vernon, Burns, Buchan, and H. H. Wright.

Education—Drs. Fowler, Geikie, Moore, H. H. Wright, Edwards, Harris, Day, Husband, Logan, Williams, Burns, Cranston, Bray, Fenwick and Buchan.

Executive—Drs. Day, and Logan.

The report of the Building Committee stated that there was a suitable site for a new college south of the School of Practical Science on College-street, and recommended that a committee be appointed to secure the site. The site which belongs to the Toronto University, can be obtained, on payment of \$500 interest on it annually to the University. The matter was referred to the Finance Committee.

June 10th 1885.

The Council met at 10 a.m.

Dr. Wright moved that all medical students engaged in the North-West, be allowed their full time, but they shall be required to take their primary examination next spring, or at the final examination.

Dr. Geikie moved in amendment, seconded by Dr. Moore, "That those primary students who had been prevented from undergoing the spring examinations by their service in the North-West, and who had paid their fees, be given their standing."

Dr. Wright argued that the Act gave no power to dispense with the examination, and the President on being appealed to for his ruling, suggested that both resolutions be withdrawn till the advice of the solicitor be obtained.

Dr. Day presented the report of the Legislative Committee. It stated that the Committee had been unable to obtain from the Legislature the amendments to the Medical Act, which were deemed so necessary, but had hopes of obtaining legislation next session. They therefore recommended the re-appointment of the Committee.

An application was received from Dr. E. B. Sparham, of Brockville, asking that his name be reinstated in the list of those licensed by the college to practice.

June 11th, 1885.

The Council met at 10.30 a.m.,

Dr. Fenwick moved that the Council examinations be held in London, as well as Toronto and Kingston. The matter was referred to the Committee on Rules and Regulations.

Dr. Cranston moved that the President, or in his absence, one of the officers of the college, shall have power to appoint in each territorial division, on the recommendation of the representative for such division, one or more persons whose duty it shall be to prosecute persons practising in contravention of the Medical Act, and that the prosecutor receive 75 per cent. of the fines inflicted. Carried.

A by-law was then passed fixing the annual assessment at \$1 per annum.

A by-law was also introduced by Dr. Williams, and passed, fixing the date of the professional examinations on the first Tuesday in April in each year.

Dr. Campbell moved that a copy of the proceedings of Council be printed and forwarded to each member of the college.

Dr. Wright moved in amendment that a synopsis of the proceedings be printed in the annual announcement, and a copy sent to every member in good standing. The amendment was carried.

Mr. Dalton McCarthy, Q.C., the solicitor of the Council, gave as his opinion that there was nothing in the Medical Act to prevent the Council from giving students in the North-West their primary examinations. Dr. Geikie then introduced a by-law to the effect that the students be allowed their primary examinations, which was carried.

The following were appointed members of the Legislative Committee: Drs. Day, Cranston, Edwards, Fowler, Williams, Husband, Douglas, Logan, Moore, Wright, Geikie, and Harris.

The members of the Council were entertained at lunch, in the evening, by Dr. Aikins, Jarvis St., in which they were joined by members of the profession in Toronto, and a pleasant time was spent.

June 12th, 1885.

The Council met at 10 a.m., the Vice-President in the chair.

Dr. Bray moved that the Legislative Committee be authorized to approach the Legislature next session with the object of obtaining the desired amendments to the Medical Act.

On the report of the committee appointed to recommend a solicitor for the council, Mr. B. B. Osler received the appointment.

The Registration Committee reported in favour of allowing F. B. McCormick, South Point, Pelee Island, to come up for registration. They also reported that the Council had no power to re-enter the name of E. B. Sparham on the register.

The opinion having been expressed by the solicitor that the University of Ottawa had no power to confer degrees in medicine, and therefore no right to representation in the Council, a reply was received from the authorities of that institution stating that they had the power to grant degrees in medicine. Dr. Grant, of Ottawa, who was present, was accordingly invited to take his seat as representative of the Ottawa University, and accepted the invitation amid great applause.

Dr. Cranston moved that a vote of thanks be passed to the Ontario Government for their exertions in perfecting the Bureau of Health. Carried.

Dr. Wright presented the report of the Education Committee, which was adopted. It recommended a change in the regulation requiring graduates of arts to spend four years in college, to three years as formerly; also that students passing the matriculation examination, shall prove their identity. It also recommended the increase of the registration fee to \$25, and the re-appointment of the examining board of last year.

Dr. Day presented the report of the Committee on Rules and Regulations. It stated that the solicitor had reported that the Council had no power to hold its final examination except at Toronto and Kingston, but that primary examinations could be held wherever the Council chose.

Dr. Henderson presented the report of the Finance Committee, which was adopted. It stated that there was a balance on hand of \$6,291.53, after all expenses had been met. The total assets, including cash on hand, building and grounds, and dues uncollected, are \$33,291.51, and total liabilities embracing the mortgage and interest, expenses of the present Council, and unpaid accounts, \$8,318.39. There is a balance in favor of the Council of \$24,973.14. The arrears of members' fees amounted to \$7,000.

Dr. Grant moved that Drs. Burns, Wright, and the Secretary, be a committee to adopt some inexpensive way of protecting the papers and documents of the Council. Carried.

Dr. Harris moved that this Council record with pleasure its sense of the zeal displayed by those medical students who have served in the North-West. Carried.

After the passing of formal votes of thanks the Council adjourned *sine die*.

## Selected Articles.

### DISSEMINATED CEREBRO-SPINAL SCLEROSIS.

BY DYCE DUCKWORTH, M.D., F.R.C.P.  
St. Bartholomew's Hospital.

GENTLEMEN,—I bring before you to-day a patient lately admitted to Bed 1, in John ward, whose case furnishes me with some points of great interest, to which I shall ask your attention. It is one of a class well fitted for a clinical lecture, which, as you know, is nothing if not demonstrative, and little more than a systematic or didactic one if the patient is not brought before you. Clinical medicine has all to do with individual cases, and that teaching of it is most proper which best illustrates the points to be noted to each of you in as direct and living a manner as possible.

I will presently tell this man to walk across the theatre, and ask you to notice his gait. If you look at him first as he stands at rest, you will not observe anything remarkable about him. You see a young man in seeming good health, well nourished, and with complete control over his equilibrium. I now ask him to close his eyes. He stands erect, and without any tremor or instability. And now, as he walks, you notice a peculiarity in the action of his right leg. This limb moves stiffly, and there is over-action of it. It is lifted higher off the ground than the other, and is clumsy in movement. We say there is some spastic action in it. I now give him this glass of water to take in his right hand. At once, you see, a violent spasmodic action occurs, vigorous tremulation, so great that he nearly empties all the water before he has well seized the glass. If he next attempts to raise the vessel to his lips, the movements become more and more exaggerated, so that all the water is spilt and the empty glass rattles against his teeth. I remove the vessel from his hand, and all the spasm ceases forthwith. As he stands quietly once more, you notice that the right arm remains tranquil and free from tremor. I try his power of grasp in each hand, and find a marked weakness in the right one, although he is a right-handed man. I now lay bare his forearms and compare the condition of his muscles. You observe no signs of wasting: the muscles are well developed and of good and equal tone on both sides. On examining his face, you see that his muscles of expression are stable and free from tremor, his lips firm, and his eye-balls quite steady. His pupils are unequal, certainly, but that is due to the action of atropine in one of them, used to allow examination of the retina of the right eye. No squint; no facial palsy. Testing his sensory functions, we find no abnormal state; all is as it should be. On enquiry as to any



subjective sensorial sensation, he assures us all is natural in each of the four extremities. To curtail our further examination, I may add that there is nothing more to be detected by any physical methods we can employ, save that the knee-reflexes are exaggerated, markedly on the right side, while no ankle-clonus can be elicited. We have, then, a seemingly healthy and vigorous young man, whose only troubles are a clumsy limping gait, due to disorderly action of his right leg, and inability to employ his right hand and arm because of powerful tremulation and disorderly spasm, which come on the instant he directs his will into this extremity; and this is all. Before he leaves the theatre I ask him to repeat a sentence after me. You notice that he speaks clearly and fluently—with a good Wiltshire accent to be sure, but without any hesitation or difficulty; and yet, again, on protruding his tongue, you find no noteworthy tremor or peculiarity in it. Let us now take up the history of this case; it is very brief.

G. R.—, aged twenty-one, a groom, was sent up to us by a former pupil of the hospital, and admitted on Feb. 14. He states that nine months ago trembling movements began in his right arm, which prevented him from following his occupation.

Later on the right leg became affected, so that he could not walk far on account of the weakness in it. Inquiry into his past history revealed no important illness. He had never had rheumatism, and there was no known history of this or of gout in his family. He had never had chorea, although his present ailment was at first believed to be of this nature. There was no neurotic history in his family, no indication of any previous paralytic attack or hemiplegia, no injury of any kind, and no history of fits. His duties entailed exposure to all kinds of weather, but to no extraordinary exposure. Previous to admission, he had been treated, we learned, with arsenic, belladonna, mineral water bathing at Bath, &c., all without avail.

You have already noted that the patient appears a healthy and well-nourished man, and that so long as he makes no voluntary efforts with the limbs of the right side of his body there is no indication of disease about him. I show you a specimen of his attempt to write his name. After violent efforts to control the right hand he made this unintelligible series of scrawls. With the left hand he has learned to write fairly legibly, but slowly and with difficulty, still without any spasm or tremor. He is awkward in setting his right forefinger on any point; thus he makes bad shots at his nose when he tries to touch the end of it, and hardly succeeds in getting near it. Dr. Stevenson has given us a report on the electrical reactions of the muscles of the affected limbs, and he states that they all react normally to both continuous and interrupted currents, and that there is no loss of electro-sensibility. We have seen the exaggerated reflexes at the knees,

especially on the affected side; and you may note an increase in the supinator-reflex of the right arm. No fibrillary muscular contractions. On examining the thorax, nothing abnormal is found. The heart-sounds are healthy and sufficiently loud. The urine is natural and the sphincters act perfectly. Special senses not perverted. No vertigo. Knows where his feet and hands are. Retinæ perfectly healthy, and optic discs well-defined. No nystagmus; pupils react naturally; no strabismus. No history of syphilis, and no signs of either inherited or acquired disease of this character. No tenderness on percussing the cranium at any point. In trying to follow with his right toes a circle drawn on the floor is he very clumsy and erratic. He can jump, though with exertion of more force than is necessary for the distance traversed. The difficulty with the right leg is best seen when he tries to run.

We find, on the whole, more negative than positive signs in this man, and yet we have very definite symptoms before us. What is the lesion here, and where is it? What is the diagnosis and what the prognosis, and the best treatment of it? I mentioned that chorea had been at first suspected in the case. Choreia is sometimes one-sided, and often so, for a time in many instances. You would not or you should not long be mistaken as to this. You know that choreic movements are incessant except during sleep, and not only elicited by effort, although they are aggravated by voluntary efforts. And you would not expect to meet with a case of one-sided chorea lasting continuously for nine months. We may, therefore, put that aside. You think, perhaps, of another nervous disorder characterized by tremors and paralysis agitans; the shaking palsy (Parkinson's disease) suggests itself to you. Is this the malady before us? Here is Parkinson's own definition, written in 1817: observe if it tallies with our case: "Involuntary tremulous motion with lessened muscular power in parts not in action, and even when supported; with a propensity to bend the trunk forwards and to pass from a walking to a running pace, the senses and intellect being uninjured." This definition will not apply here. The rule is for the tremor to be persistent and constant in shaking palsy, and rather to cease or moderate when action is induced. The contrary is the case here. Action at once induces tremor. The age of this patient is against his being the subject of shaking palsy, this disorder being very rare before forty years of age are reached. Have we here to deal with a case of so-called post-hemiplegic chorea? I think not, because we have no history and no signs of a past attack of hemiplegia, and the characters of this man's tremors are not those of the disorder I have alluded to. To mention mercurial tremors is sufficient. These are symmetrical, and affect the head, and the signs of mercurialism are always obvious. We can also exclude hysterical tremors and malingering.

We are brought, at last, to consider this case, then, as one of a class known as insular or disseminated cerebro-spinal sclerosis, or Charcot's disease, as it has been called. It is a remarkable example, certainly, because the disorder is, at present—note, I say, *at present*,—*hemiplegic in character, and also manifestly in an early stage*. We do not often see such cases. This is our diagnosis: sclerotic patches situated in the left half of the brain, possibly in the corpus striatum or crus, and possibly in some portion of the medulla spinalis. I should not like to pronounce with greater certainty anything more than this at present, though I might exclude the inferior frontal convolution and parts around the fissure of Sylvius, with some other regions. We may exclude scrofulous and syphilitic disease in the case, and we are in face of the characteristic lesions which are usually found in these cases, and for which I refer you to your studies in morbid histology. The age of our patient is just that at which this malady declares itself. It is equally common in each sex, and very rare after forty. Exposure to cold has been a commonly assigned cause. In this disease no muscular *wasting* occurs, although loss of muscular *power* is found, and no electrical changes arise. Paresis precedes the tremors, and the reverse is the case in shaking palsy. The reflexes are exaggerated. I should not omit to point out to you that many symptoms are wanting in this patient to complete the picture of a typical case. Such a one we had fifteen months ago in John ward. For example, one looks for nystagmus, and for certain symptoms referable to disorder in the medulla oblongata in most of these cases. I never met before with the exact conditions you see in this man; but, still, I have hardly any hesitation in making my diagnosis.

As to prognosis. This is certainly grave. I surmise that we have so far only early symptoms before us, and that the disease will make sad progress in time. We may fear the onset of paresis and tremors in the sound limbs, and the implication of speech with what are termed bulbar symptoms. The sclerotic process may spread and new patches of it occur in other portions of the cerebro-spinal system, thus setting up new symptoms. The course of the malady is slow, and may occupy from five to ten years. Deceptive periods of improvement may occur from time to time. Too often the disease goes on from bad to worse till the patient is rendered helpless and bedridden, the limbs becoming rigid and paralytic dementia supervening. Can we do nothing to arrest this terrible process? Must it go on to the bitter end? Alas, the resources of our art are, we must honestly avow, powerless as yet to avert the progress of this terrible malady. Physicians have been very assiduous in elaborating the differential diagnosis of nervous diseases of late years, but in respect to therapeutics we have as yet scored few triumphs. The outlook

is bad, and we might almost despair of rendering help. We shall never do this, I hope, but rather strive the harder to find means of arresting this untoward process. No one drug is pre-eminently indicated. I am giving this man mercury, and mean to bring him fully under its influence. He takes three grains of blue pill each night. Not that I am trying to eradicate any syphilitic taint, for, in truth, we know of none in this case. But we know that mercury is a powerful drug, and able to modify nutritional force very materially. We shall do our patient no harm with it. It may be that some of these obscure perversions of growth are evolutionary forms of syphilis transmitted from infected ancestry, and so mercury, fully tried, may chance to be of special use. We know, at any rate, that in the peculiar form of systematic sclerosis of the posterior spinal columns known as the *tabes dorsalis*—locomotor ataxia—syphilis plays a very prominent part, to the extent, indeed, of eighty per cent., or more, of all cases. Not that the lesion is itself directly syphilitic or gummatous, but that syphilis, as syphilis, seems to predispose to the particular form of sclerotic change in the cord which sets up the disease we know as *tabes dorsalis*. We are also maintaining the nutrition of this man's nervous system by cod-liver oil and a good diet. Nitrate of silver has been found of use in early stages of this disease. But for some time to come I should prefer to use mercury and iodide of potassium and carefully watch their effects, and I shall bring the results and the further history of this remarkable case before you on a subsequent occasion.—*Lancet*.

#### THE "HAMMOCK" MODE OF APPLYING THE PLASTER JACKET.

Dr. A. B. Hirsh, of Philadelphia, gives the following, in the *Med. & Surg. Reporter*:

What physician who has ever treated spinal deformities has not lost temper when using ordinary *suspension* to apply the plaster jacket, when the patient has almost been strangled by a sudden slipping of the straps sustaining the head, or has fainted or become utterly unmanageable? Then, too, there is the discomfort to the patient of keeping up a constant muscular strain, in a peculiar position, for a more or less lengthened period; while if (as usual) he or she be young in years, the fear or even fright of the patient adds to the unpleasantness of the whole affair. Of course, the expense of the necessary tripod and accompanying apparatus is also not the least item to the practitioner.

These thoughts were suggested by seeing Professor Nancrede recently apply a plaster jacket at St. Christopher's Hospital, before his polyclinic class. No originality is, I believe, claimed—an English surgeon first having suggested the ham-

mock for this purpose. In this case, a poorly-nourished Irish lad, aged some eight years, had the corset applied for a posterior dorso-lumbar curvature, although the doctor explained that any and every variety of spinal deformity could be treated by a modification of the same method.

A piece of ordinary "ten-ounce burlap"—the bagging used to wrap around rolls of carpet, etc.—some seven feet in length and three feet in width, was suspended between the two sides of the room. Each end of the canvas has a "casing" about one and one-half inches wide, strongly sewn, and a rope drawn through the space thus made (so as to "bunch" the end), which is then attached to a heavy hook or ring screwed into the wall, with a compound pulley and rope to render taut the swing; here we have the convenient hammock as required.

The lad, devoid of clothes, except a woolen undervest, was next placed therein, face downwards and with hands and feet extended—the former grasping the sides of the hammock, so as to exercise some extension—and a hole was cut through the bottom of the swing opposite to the nose and mouth, so as to allow him to breathe easily. Care was taken to fit the usual abdominal pad, and to keep the hammock well balanced. The hammock was then cut transversely on a level and down to the iliac crests; the same was done at the upper margins of each axilla. The flaps thus formed were folded around the body, the surplus portion removed, and the whole roughly sewn up, thus forming a second undervest around the woolen one. Starting from above, the bandage was now carried around the body until the deformity was completely covered, the canvas being, of course, included in the turns. The plaster was allowed to set, and the patient relieved from his swing by cutting loose the burlap above and below the jacket, and the procedure was complete. At no time was discomfort complained of, as the little one even joked about the novelty of his situation.

The professor proceeded to explain that this hammock achieved all the good that Sayre's swing did, and obviated all its objectionable features. On the latter, the curves above and below the gibbosity were straightened out, as well as any lateral deviation, and thus the apparent increase in height was obtained, while the weight of the body, by a true process of leverage, effected through the over curved portions of the spine, above and below, theoretically tended to separate the softened and diseased anterior surfaces of the vertebral bodies. Whether this latter result was desirable, if obtainable to a marked degree, was more than doubtful in the lecturer's mind, as he thought all that should be aimed at was to remove the weight of the trunk, head, and upper extremities—one or all, according to the portion of the diseased vertebræ—and to place the column in the best position attainable, for ankylosis and future usefulness. In the same way, the prone

position in the hammock effaced the curves, and, by leverage, tended to separate the anterior surfaces of the vertebral bodies. The degree to which the hammock was allowed to "sag" would determine the amount of extension exerted upon the spine.

This method was cheap, comfortable and always available, without any special apparatus, beyond bagging, ropes, and strong screw hooks, staples, or some similar contrivance. The patient might be allowed to swing for hours, until the plaster was perfectly dry, thus obviating the risk of cracking the jacket, which sometimes happens when the patient is perforce, taken down too soon from Sayre's swing, on account of fainting, etc., as the professor had experienced in his own practice. The screaming, struggling, and terror, so common with children, is all done away with. It is the part of wisdom to place a mattress on the floor beneath the hammock, lest any part of the apparatus break, and a serious fall result. The professor now always resorted to this method of applying the jacket, and was perfectly satisfied with it.

#### INTERNAL SPINA-BIFIDA.

Dr. Thomas was consulted by a married lady, aged twenty-eight, two years married, but sterile. She complained of nothing but pain in sacral region, and sense of weight. On examination he found a sac filled with fluid, occupying the cavity of the sacrum, and pushing the rectum aside slightly, but in no way occasioning serious inconvenience. He believed the failure to conceive was due, not to the pressure of this tumor, but to a congenital sharp ante flexion, and advised non-interference. The case stumped the doctor—he didn't know what to make of it—though he examined the case repeatedly, at intervals, for two years, when he lost sight of it. Some time afterwards he was consulted by a beautiful girl, nineteen years of age, who appeared to be perfectly healthy, but who suffered from dysmenorrhœa. She was engaged to be married, and she and her mother were anxious to have any impediment removed that might be in the way, and hence the consultation. Dr. Thomas found a sac filled with fluid, situated in the curvature of the sacrum, and impinging on the vaginal canal to such extent as to almost completely occlude it, and this, the doctor thought, was the cause of her dysmenorrhœa. He strongly advised non-interference, stating that in view of the obscurity of the case radical measures were not justified. Mother and daughter insisted, and finally the doctor consented to a compromise—he would aspirate the sac. He did so with the smallest-sized Dieulafoy's needle, drawing off eight ounces of perfectly limpid non-albuminous fluid, which was submitted to Dr. Garrigues for examination. Dr. G. declined to

give an opinion of the nature or source of the fluid. The effects of this operation were alarming; the girl was thrown into violent fever with headache, which lasted several days. This was attributed to the "thief in the community," malaria, and treated with quinine and morphia hypodermically. Some six months afterwards, the patient and her mother called again: the sac had refilled, and they renewed their importunities for an operation. Dr. Thomas was strongly impressed with the impropriety of any operation, especially in view of what had just been related, and was possessed, he says, of a strange feeling of dread and fear. However, he yielded. He would open the sac, and establish drainage. With proper assistance, patient in lithotomy position and anæsthetized, Dr. Thomas made an incision into the sac and stitched the edges to the vaginal opening. There was discharged about half a pint of the same clear fluid, resembling hysterical urine. In five hours, at 8 p.m., she was seen by Dr. Dubois, one of the assistants; severe headache and marked tendency to hysteria. In the morning, headache more severe, pulse 110, temperature 102. In the evening, symptoms same, with a peculiarly wild and and maniacal expression. Still the doctor did not suspect the real nature of the case. Next morning all symptoms were favorable, but in the afternoon the physician was summoned in haste to see her. Found her in a condition bordering on hysterical mania, with pulse 120, and temperature 104, with strong tendency to opisthotonos, and showing marked signs of incipient tetanus. "Now," says the doctor, "there suddenly flashed across my mind the full recognition of the case; an exactly similar one, which had occurred to Dr. Emmet in the Women's Hospital, came back to my memory, from which, until now, it had been entirely effaced; and, as if a curtain had been lifted, I saw clearly what had, until this moment, been so obscure. I had opened a sac formed by the meninges of the cord, which had projected through an imperfection in the sacrum, into the pelvic cavity. The membranes of brain and cord were deprived of the rachidian fluid, and the consequences were before me! I at once collected my assistants, and anæsthetized the patient with chloroform, and sewed up the opening in the sac. \* \* \* Whether from chloroform narcosis or not I cannot say, but for some hours after this, the patient markedly improved, and I had great hopes that I had retraced my unfortunate steps in time; but about twelve hours after the closure of the sac the heart suddenly failed, opisthotonos occurred, the patient shrieked from severity of her cephalalgia—and died!"

In the conclusion of this most interesting record, Dr. Thomas says:

"Where a cyst is found in the pelvis, behind the rectum, filling the hollow of the sacrum, appar-

ently attached to that bone, let the diagnostician carefully exclude the possibility of its being spina-bifida before interfering with it."

2. "If it be decided to interfere with such a tumor, let a small portion of the fluid be first drawn by a hypodermic needle, and if this be found to be a limpid, non-albuminous fluid, let the probabilities of the sac being connected with the meninges of the cord receive due consideration, and guard against further interference.—*Am. Med. Digest.*

## HYSTERECTOMY FOR UTERINE FIBROIDS.

Dr. W. T. Lusk presented a large fibroid tumor (*N. Y. Obstet. Society*), together with a number of smaller ones, which had been removed, with the uterus, from a patient who gave the following history: She was thirty-eight years of age, and entered the hospital in March last, suffering from ascites and some form of abdominal tumor. The ascites was so great that it was impossible to determine the exact nature of the tumor. The patient was greatly reduced in flesh and in general health, and was passing only from one to five ounces of urine daily. It seemed hardly possible that she could live more than a few weeks. Dr. Lusk removed a portion of the ascitic fluid, after which he was able to make out what he supposed to be a large fibroid of the uterus, although he was in some doubt whether the case might not be one of abdominal pregnancy. After the patient had been under observation for some time he became convinced that it was one of multiple fibroids of the uterus, there being one large tumor and a number of smaller ones attached by pedicles. Mr. Tait, who had been asked to examine the patient, had summarily rejected the idea of uterine fibroma, and, when asked what he thought the condition was, had characteristically replied, "Cut the patient open and find out." Several other gentlemen, however, who saw the patient a day or two later, coincided in Dr. Lusk's diagnosis. Dr. Lusk was surprised, on returning from the country after the summer, to learn that the patient was still alive, and had even improved somewhat in condition. The house physician had been giving her acetate of potassium and digitalis, and so long as these medicines were continued the urine was secreted in normal quantity, but as soon as they were withdrawn it decreased in amount and her condition grew worse. Her desire to go home was acceded to soon after Dr. Lusk's return to the city, but she had scarcely been absent twenty-four hours when the dropsy largely increased in amount, and she returned and was again given acetate of potassium and digitalis, with the effect of increasing the urinary secretion. The urine contained albumen. It was evident that the patient could not live much

longer without interference, and yet the kidney complication and ascites made recovery after an operation extremely doubtful. It was decided, however, to make an abdominal section, Dr. Lusk's idea being that if only a single fibroid was removed it would tend to make the patient relatively comfortable. The operation was performed about seven weeks ago. When the peritonæum was opened, about a gallon of ascitic fluid escaped. It was the operator's intention to remove the fibroids one after another, but they proved to be very numerous, and, accordingly, he turned out the entire mass, threw a powerful, large-sized rubber cord around its pedicle and cut it away.

The only point to which he wished to call special attention regarding the operation was the fact that, after the method of most operators in such cases, he introduced the needle, intended to fasten the pedicle to the abdominal walls, through the stump below the ligature. This he now regarded as a mistake, and, on account of the distress which it caused the patient, he withdrew the needle on the third day and passed it through the stump above the ligature, which afforded some relief. The day following the removal of the needle some febrile disturbance developed, which was found, on lifting the stump with a tenaculum, to be due to a collection of about a teaspoonful of pus in the upper portion of the wound. The next day the temperature rose again, and it was then found that there was some pus in the lower portion of the wound. As soon as this fetid pus was washed away the temperature fell, and convalescence was thenceforward uninterrupted. There was no further kidney trouble after the operation; the urine was secreted in normal quantity, and no longer contained albumen. This fact was worthy of note, because it was stated in works on obstetrics that inefficient action of the kidneys in puerperal eclampsia was not due to pressure of the gravid uterus, otherwise a like trouble would arise from pressure of ovarian and fibroid tumors. Here was a case in which pressure was made by a tumor, and removal of this caused albumen to disappear from the urine immediately, and the fluid to become secreted in normal quantity. In reply to a question, Dr. Lusk said the entire uterus was removed with the tumor, which weighed seven pounds and a half; the stump separated on the twelfth day. He had had the valuable assistance of the president during the operation.

The President asked Dr. Lusk, who had spoken of tympanites (which was present in this case) as being the rule, if this was true of all cases of extirpation of the uterus, whether the stump was treated extra-peritoneally or not. Dr. Lusk said he meant to refer only to those cases in which, the stump being short, the pressure of the needle was very near the descending colon.

Dr. J. B. Hunter remarked, with regard to the effect upon the kidney of removal of the tumor,

that recently, in two cases operated upon by two different surgeons in this city, the urine, which had been apparently normal, became completely suppressed about the seventh day after the operation, and the patients died. The cases had progressed favorably until suppression of the urine had taken place. Dr. Hunter also remarked that he had employed the rubber cord, shown by Dr. Lusk, with satisfaction.

The President had reported a case last spring in which he hesitated to operate for the removal of a fibroid tumor, because the urine contained albumen, but, instead of suppression of urine after the operation, as had been feared, the albumen disappeared and the secretion became normal, showing clearly that albuminuria had been due to pressure of the tumor upon the kidneys or upon the ureters.—*N. Y. Med Journal.*

#### MOTOR APHASIA FROM INJURY, WITHOUT PARALYSIS OF ANY OF THE LIMBS.

Dr. J. H. Burns reported the following case to the Toronto Medical Society (*Med. News*). Mr. K., æt. 56, healthy and robust, fell down stairs; he was assisted to his feet and with help walked to a chair. He did not then speak or at any time subsequently. He became unconscious about three hours later. In my absence Dr. Duncan saw him that evening for me, and with me the next morning, by which time he had recovered consciousness and was able to leave the bed. His bowels had been freely moved with croton oil. There was an injury to the soft tissues over the right eye, but no fracture could be made out. He swallowed with great difficulty; there was neither motor paralysis nor anæsthesia of any part of the limbs. Twenty-four hours after injury pulse was 100, temp. 101°. Dr. Workman saw him in consultation following morning; temp. 104°, pulse 120. During the afternoon he had a convulsion and after that convulsions recurred every ten minutes till he died at 2 p.m. next day. The left side was most affected with the convulsions. During this time there was retention of urine. Death took place sixty-eight hours after injury.

Post-mortem seven hours after death. Extravasation into subcutaneous tissue over parietal and temporal bones of right side. There was an extensive fracture in this region, with slight depression. Dura mater intimately adherent to calvarium. A large clot was found between dura mater and skull at seat of fracture. Great congestion of cerebrium beneath this. Another clot was found beneath the dura mater on left side of brain opposite seat of injury, with extensive disorganization of the lower part of middle lobe of brain on left side. Heart

and lungs normal, liver small but apparently healthy, kidneys healthy.

Dr. Duncan, who assisted at the autopsy, said there were two distinct clots on the left side; one in the arachnoid space pressing on the temporo-sphenoidal lobe, another beneath this in the brain substance, in which on removal of the clot there was a laceration half an inch deep and one and one-half by one and one-fourth inches in extent. This clot probably resulted from rupture of a branch of the Sylvian artery. From symptoms, he had expected to find some such injury. The presence of *three* distinct clots was an unusual circumstance.

Dr. Workman said that he visited the patient in consultation on the 13th of April, and he is able to confirm all that has been stated. The symptoms that most attracted his attention was that of motor-aphasia unaccompanied by any paralysis in the lower or upper limbs. The only mark of external injury was the swollen and blackened state of the right eye. Close examination of the supra-orbital region of the frontal bone gave no indication of fracture, nor did examination of the side of the cranium present any. The patient had evidently free use of the muscles of the arms and legs. When he saw him there was no stertorous breathing, neither was pronounced coma present, but there was a certain degree of torpor or somnolence, which he apprehended would culminate in coma. He had not spoken from the time of occurrence of the injury, neither had he taken any drink or food, most probably because of the paralyzed state of the glosso labial muscles. The large extravasation of blood in the left temporal region, the result of the *contre-coup*, showed that some important vessel, most probably a branch of the Sylvian artery, had been lacerated, and it would appear from Dr. Duncan's statement that the cerebral substance in the Sylvian region was greatly injured. He had no doubt that this part coincided with the foot of the ascending frontal and the posterior part of the third frontal convolution, in which are the motor-centres for the speech muscles and for those of deglutition, etc. The absence of any mark of injury in the vicinity of the fissure of Rolando, accounts for the persistence of muscular power in the arms and legs. He regarded the case as one of much interest, in confirmation of the now so universally admitted doctrine of cerebral localization.

#### TREATMENT OF INFECTIOUS SORE THROAT.

I always administer an emetic in the beginning. As long as vomiting lasts and the tongue appears coated, I give as little nourishment as possible. All my patients were young and vigorous, so that, instead of stimulating, I had more than once the

idea of bleeding, and would have done so, on account of the active inflammation, had not the feeling of general debility which attends these cases restrained me. This period usually continues to the third day, when, the irritability of the stomach having ceased, I let them take fluid but nutritious food, returning to solid aliment as soon as the condition of the pharynx permits its being swallowed without injury to the inflamed parts. I further advise the patient to use the following gargle every ten or fifteen minutes:

R—Acid salicylic,	5 j.
Acid carbolic,	℥ xxiv.
Sodii borat.,	gr. lxx.
Glycerine,	f 3 j.
Aqua distillat.	f 5 xj.—M.

Sig.—Use as a gargle.

Internally I order a teaspoonful, in half a tumblerful of water, of this medicine:

R—Quinine hydrochlorat,	gr. xxxvj.
Tinct. ferri chlorid.,	f 3 j.
Acid muriat. dilut.,	f 3 ij.
Tinct. cardamom comp.,	
Glycerine,	
Syr. aurant. cortic., aa q.s. ad.,	f 5 iij.—M.

This is taken every three or four hours until the more moist appearance of the tongue and the general condition of the patient indicate amelioration of the symptoms, when the size and the frequency of the doses are rapidly diminished. As soon as the first indication of disturbance of the urinary function sets in, I prescribe a teaspoonful of infusion of digitalis, to be taken every four hours. When the secretion has been re-established, I still continue for one week longer the same dose; for another day the patient is directed to take it but three times daily, and then this medicine is stopped, having achieved its purpose. If the pain in the neck or in the shoulder be very severe, I have found the best result from this liniment:

R—Chloral hydrat.,	5 j.
Camphoræ,	5 ss.
Ol. amygdal,	f 5 j.—M.

Sig.—To be applied with a camel's hair brush to the painful parts, the application to be renewed on return of pain.

Besides paying attention to the bowels and employing general measures, as regular feeding, cooling drinks, sponging of the body several times daily, etc., the above contains the whole treatment. For the sleeplessness commonly met with in the beginning I have ceased to prescribe, as experience has taught me that the patients feel better, regain sooner their natural sleep, and recover more quickly, when no hypnotic whatever is employed.—*Hugo Engel, M.D., in Phil. Med. Times.*

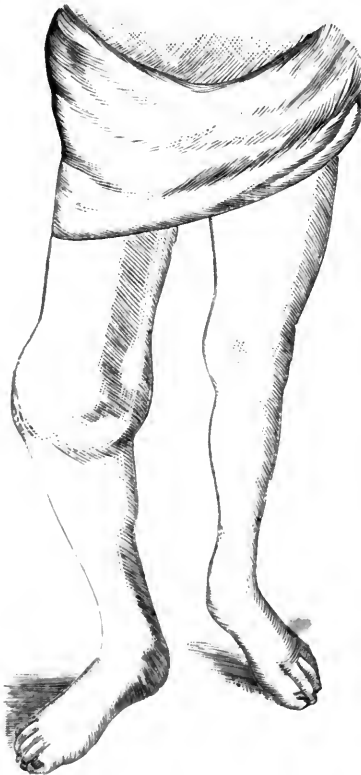


## CHARCOT'S JOINT DISEASE.

[Dr. A. Sydney Roberts, of Philadelphia, gives a report of six cases of Charcot's joint disease in the *Med. News*, Feb. 14, 1885, from which we select the following case (iv), with illustration.] ED.

Dr. A. A. Y., male, æt. 65, resident of Hammon-ton, N. J. Examined the patient with Dr. S. Weir Mitchell on January 16, 1885. For the substance of the following notes I am indebted to Dr. Wood-nutt.

Hereditary history of patient excellent. He had always been strong and healthy during youth, and up to 1865, though a hard-working farmer. An army life, and three years of extreme exposure prior to the close of the war, found him suffering in 1865 from sharp, wandering pains in the upper and lower extremities; never noticed, however, in



the articulations. Loss of power followed in the right leg. Three years later suppurative arthritis attacked the metatarso-phalangeal articulation of the right great toe, and last phalanx of left ring finger, sequestra coming away in each instance.

During 1870 the patient first noticed an œdematous swelling of the right elbow; following shortly upon this, the wrist joint of the same arm gradually and painlessly enlarged. Then a distension of the capsule of the right knee-joint succeeded. The enlargement of the latter articulation was more

rapid than either the wrist or elbow. Rheumatic pains in the joints accompanied the swelling and deformity.

The left limb has been comparatively exempt from pain. Recently, however, the capsule of the knee-joint has become distended and elastic. The elbow tumor has diminished somewhat in circumference during the past four years.

During the past year the distal phalanx of the right index finger has gradually atrophied, without inflammation, and is entirely wanting. The nail and finger end are normal, though somewhat shortened. Pain, at present, is chiefly in both feet, paroxysmal and erratic, often attacking corresponding points on the legs.

The present appearance of the right elbow and knee joint enlargements exhibit an irregular nodulated hypertrophy, bearing no resemblance to normal joint outline, and consisting chiefly of osteophytes and abnormal increase of synovial fluid. Motion preternaturally free in all directions; structure of joints apparently entirely destroyed.

*Remarks.*—The joint lesions first appeared in this patient after ataxia had become established. The appearance of the affected elbow and knee is that of an enormous nodular hypertrophied mass of bone, doubling their normal circumference, associated with synovial distension of the capsule. Osteophytes readily movable with the capsule, and varying in size from a pigeon's egg to that of a turkey.

The atrophy of the distal phalanx of the right index finger is especially to be noted. It is the first instance of complete absorption of the diaphysis of bone that I have had an opportunity of observing

## PLASTER JACKET—NEW USE FOR.

Dr. McLellan, of St. Marys, Kas., gives the following in the *Lancet and Clinic*, Cin.:— In reading of the uses to which the plaster jacket is put, I have never seen it recommended for the relief and cure of weakened and painful conditions of the spinal muscles, caused by injury, disease, etc., and I think I can make myself more clearly understood by relating two instances from among others, not only where it gave instant relief, but performed a permanent cure. While I was yet a student, (1869, Jan.) I suffered from an attack of typhoid fever, which ran its natural course, and I was convalescent in about eight weeks, and by over-exertion I suffered a relapse, which lasted much longer than first attack. When I got able to be around, I suffered untold agony from pain in the lumbar region and down the course of right sciatic nerve, and at times along the Psoas Muscle, and if I was not near something to catch hold of, would fall, for I could not endure the pain. Cupping, blistering, and all external as well as internal remedies, were



used, but all the relief I could get was from hypodermics of morphia, and I had to take from three to four per day to make living endurable, when I thought the plaster jacket might give me support and relief, and without the aid of anyone I applied a jacket to myself by standing in the position most comfortable, (which was perfectly erect). As soon as the plaster set, I could go around without any pain, and I stopped the morphia then and there, which had got to be considerable, and had no more pain. In less than three months I was perfectly well, and had gained more than thirty pounds, and used no other remedy than the jacket.

CASE 2.—In December, 1883, S. H., aged 19, spare build, came to me, suffering intense pain in the lumbar region and down course of both sciatic nerves. At times the pain was so severe that he would shake as though he had an ague chill. He stated that in September of same year, while making hay, he was helping to put a hay ladder upon the waggon, when the one that was helping him let his hold slip, and all the weight came on him. He sprained the muscles of his back, which grew worse and worse, and, as he stated when I first saw him, he did not want to live the way he was, and as he had already passed through the hands of about three doctors, all regulars, I took it for granted they had used all the usual remedies, so I thought I would try the plaster jacket, and I did so, with the same happy result, no more pain and a rapid convalescence.

OVARIOTOMY IN ENGLAND.—In these days, when continental journals vie with each other in publishing disagreeable remarks about England, it is pleasant to find how, on the other hand, writers in the United States are almost unanimous in sounding praises of our government, our institutions, our towns, our country, and our surgery. *Harpers' Monthly* has just discovered beauties of landscape in the Regent's canal, whilst, in the *Atlanta Medical and Surgical Journal*, the distinguished Dr. Robert Battey devotes an article to a subject which has been looked upon with more pride and interest than that useful waterway by qualified and unqualified Britons, namely, the progress of ovariectomy. The extraordinary results which have been obtained in Great Britain within the past three years, seventy-three consecutive operations in the hands of one surgeon, and seventy-six in the hands of another, without a death, are well calculated, observes Dr. Battey, to excite both astonishment and admiration, American results being far less satisfactory. Dr. Battey, enters into a consideration of the conditions of our success. Experience he considers to be the first of these conditions. If the best results are to be obtained in America, ovariectomy must, he believes, be put into the hands of a few, and the

general practitioner must forego the ambition of swinging here and there an occasional scalp to his girdle. The second condition is "clean hands and appliances;" the third, a clean apartment and bedding. The fourth is "pure atmosphere and free ventilation;" and Dr. Battey's allusion to "the upper floors of buildings in elevated urban localities, with surroundings as salubrious as circumstance will admit," probably refers to the Samaritan Free Hospital. The fifth condition is thorough cleansing of the abdomen. Dr. Battey agrees with those English, Scotch, and Irish operators who employ the drainage-tube when the "toilet" of the peritoneum is from any cause incomplete. The sixth condition is skilled nursing and quietude; the seventh, early operation; the eighth, complete intraperitoneal ligature of the pedicle. The last condition of success is antiseptic solutions and spray. He admits that "the results obtained by Dr. Bantock, in London, and Mr. Lawson Tait, in Birmingham, seem to show conclusively that the use of these solutions is not indispensable to the attainment of the best success. They have both shown by their work that scrupulous attention given to the cleansing of hands, instruments and sponges, not only prior to operating, but frequently during the progress of the operation, is sufficient. The frequent removal of the blood from hands and implements appears to protect the abdomen from septic influence." Dr. Battey then speaks of Dr. Keith's objections to the spray. Nevertheless, Dr. Battey himself is not inclined to give up complete antiseptic precautions. He has never had a case of carbolic acid poisoning, and concludes by observing: "To the criticism that carbolic solutions weaker than one to twenty have been shown in the laboratory to be impotent for the destruction of bacteria, I answer that I am seeking by its use only the restoration of my patients to health, and the mortality in my hands since its use has dropped from twenty-five per cent. to zero. This, for me, is sufficient reason for the continuance of the method, and for the rejection of all other substitutes, until such time as more complete demonstrations shall place a clearer light before me." —*Brit. Med. Journal*.

CHLORIDE OF GOLD AND SODIUM IN SOME NERVOUS AFFECTIONS.—In an interesting paper on this subject (*Medical News, Maryland Medical Journal*), Dr. Roberts Bartholow relates some important facts bearing upon the use of gold as a therapeutic agent. Gold is mentioned as a valuable remedy in the treatment of melancholy in medieval history, and afterwards it was used by the Arabians and Italians. Its therapeutic powers are grouped under three heads:

1. According to its so-called alterant effects.
2. According to its action on the nervous system; and

### 3. According to its urino-genital properties.

Referring to the preparations used, Dr. Bartholow prefers the double chloride of gold and sodium, which he prescribes in the dose of one-twentieth of a grain. In this quantity, twice or three times a day, it appears to have, as its primary action, the power to promote constructive metamorphosis, to improve the globular richness of the blood; and to increase tissue-strength. The tissue yielding most readily to its use are the connective, and especially those of pathological formation. Hence the remedy is considered especially useful in sclerosis, whether nervous, hepatic or renal. In posterior spinal sclerosis, and in chronic interstitial nephritis, Dr. Bartholow has found the gold salt very efficacious. When used in locomotor ataxia, early and persistently, it has seemed to him to have the power of arresting the disease. Dr. Bartholow has observed excellent results following the use of the gold chloride in many cases of fibroid kidney. In a form of hypochondriasis, coincident with the onset of degenerative changes in the cerebral vessels, he has found gold and sodium chloride very effective. When persistently used, the uneasiness in the head, the vertiginous and other abnormal sensations subside, the mental oppression at the same time clearing up.

In certain affections characterized by spasm, as asthma, laryngismus stridulus, and singultus, Dr. Bartholow has seen this remedy act surprisingly well. In urino-genital affections the gold has great value, and cases of chronic albuminuria have been observed in which the curative effects of the remedy have been most conspicuous.

In certain cases of sexual debility, in dysmenorrhœa with scanty menstruation, and in chronic metritis the persistent administration of gold and sodium chloride has done much good. Dr. Bartholow indicates the direction in which the remedy promises to be useful, but is of the opinion that wider and more varied experience is necessary to fix its real position. It seems to us from this statement, made by Dr. Bartholow, that the remedy in question possesses very valuable powers, and is destined to awaken considerable interest. Its actions and uses are worthy of most careful study.—*Medical Review.*

**RUPTURED EXTRA-UTERINE PREGNANCY.**—Another woman has passed from health to the grave in a few hours; another home has been made desolate; and another victim to delay and palliative hypodermatics of morphia and brandy-and-water in drachm doses has been added to the list, already too long, of cases that have been lost for want of surgical treatment.

A case has been recently reported, in a western medical journal, in which the symptoms of rupture of an extra-uterine fetal sac were complete, and the diagnosis of extra-uterine pregnancy was con-

curring in by three practitioners, and the following treatment adopted: "Sulphate of morphia in one-sixth-grain doses, hypodermatically, to control the pain, and brandy, both by the mouth and under the skin, as a stimulant. A sinapism over the stomach and bowels assisted in giving some measure of relief." The patient died in sixteen hours and a half. Nothing is said of an attempt to control the hemorrhage, which every one must have known was draining away the woman's life. Nothing is said of a desire to open the abdominal cavity to stop the hemorrhage and remove the foreign body. Is the recorded experience and the teachings of the surgical leaders of the day to go for nothing? Are there any who think that a patient in this situation dies of aught else save hemorrhage, and controllable hemorrhage? If the hemorrhage be not controllable, why do the patients live for sixteen and twenty or thirty hours after the rupture? Are there those in the profession who do not know that the mere exposure of the abdominal cavity to the air will often check a hemorrhage which would otherwise prove fatal in the closed cavity? Surely in these days of great and brilliant triumphs in abdominal surgery, when patients recover after intestinal wounds, and resections, when the most desperate "forlorn hopes" recover, one should not hesitate to open the abdomen in a case of this kind, when two or three ligatures and some clean water are all that are required.

There is no palliative measure for a ruptured extra-uterine cyst; there is no expectant treatment; and there is no other way known to medicine by which a woman in this condition can be reasonably expected to survive save by the prompt use of the knife—and there is no reason for thinking that she would die if this be resorted to in time. And until she is practically dead it is never too late to try and save her.—*N. Y. Med. Record.*

**SUBPERIOSTEAL AMPUTATION.**—A paper by Dr. Nicaise, read at the International Medical Congress in Copenhagen, is published in the *Revue de Chirurgie*, No. 12, 1884. In 1859 M. Ollier first demonstrated the utility, in amputating, of preserving periosteum, in order to close the medullary canal, and to favor union by primary intention. At this period, however, the suppuration that almost constantly attended the healing of stumps rendered attempts to preserve this membrane quite useless, and so for a time they were abandoned. Since the introduction into surgery of Lister's antiseptic method, further trials have been made under the improved conditions, and the practice has been advocated by Esmarch, Volkmann, Maas, Trelat, and others. Since 1881, Dr. Nicaise has in amputating always preserved a portion of periosteum beyond the end of the bone. As this

membrane retracts very much when detached from its bone, it is thought always necessary to take up a long 'cuff,' the length of which should be about equal to the diameter of the bone at the point of section. Esmarch and Maas bring together the free edges of the process of peritoneum by a suture of prepared catgut; Nicaise does not apply a suture, but allows the long cuff to form over the end of the bone a kind of hood. It has been proved by experiments on animals that a flap or loose process of periosteum rapidly closes the open end of the medullary cavity, and that on the inner surface of this occluding membrane a thin layer of osseous tissue is formed. M. Nicaise alludes to a case of amputation of the thigh for chronic disease of the knee in a tuberculous man, aged 42. After death, which occurred twenty-nine days later, when the stump had almost entirely healed, the lower extremity of the divided femur was found completely closed by a septum of thickened and granular periosteum, above which was a layer of newly formed bone-tissue, about one-fifth of an inch in thickness. It has been shown by LeFort and Trelat that a minute flap of muscular tissue brought over the end of a divided long bone will contract adhesions, close the medullary cavity, and even form a thin layer of osseous tissue. M. Nicaise, however, holds that, when a flap of periosteum is applied, the end of the bone is in immediate relation with a membrane that physiologically is best adapted to the purposes of protecting and forming osseous tissue. It has been objected to the preservation of periosteum in amputation, that this practice favors the formation of irregularly shaped osteophytic growths. Such growths, however, according to the author, are formed only after suppuration in the stump, or osteitis at the extremity of the bone.—*London Med. Record.*

**POISONED BY COLORED STOCKINGS.**—Again and again have medical journals warned against the wearing of cheap colored underwear. As these materials generally consist of cotton, at least to a great extent, the coloring stuff is not always an innocuous, but frequently a dangerous one.

The latest case of this kind is reported by Dr. O. Seifert, in the *Wiener Med. Wochenschrift*, 1885, 38. A young lady æt. 26, had been wearing stockings, which had been colored by an anilin-red, containing a large percentage of arsenic. She was suddenly seized with all the symptoms of a gastro-enteritis and an acute hæmorrhagic nephritis; besides, an eczematous skin-eruption made its appearance on the dorsal surfaces of both feet. The treatment first gave a very unsatisfactory result, until the cause was discovered, when the patient was cured of her disease within three weeks. The urine, however, for a considerable time afterwards, contained a small amount of albumen, though this finally also disappeared.

There ought to be a sanitary inspector, not only for all food—whether solid or fluid—that is offered for sale, but also for articles of wear. The demand for cheaper goods, and the great competition, has made many manufacturers reckless, and they seem to care very little if they injure the health of individuals, if they can only produce goods which are cheap and showy. As not every buyer can be an expert, purchasers ought to be protected by law, making the poisonous or any adulterations of any article offered for sale, a criminal offence, and appointing inspectors for the purpose of investigating and discovering all dangerous swindles of that kind. Meanwhile, it would be best for all buyers to avoid all cheap articles, which mainly attract attention by their bright colors. In wool, the danger is not so great, as woollen materials may be easily dyed by innocuous vegetable coloring matters.—*Med. & Surg. Reporter.*

**THE TREATMENT OF WHOOPING COUGH.**—The treatment of this disease should be of two characters, one of which is addressed to the catarrhal and the other to the nervous element. Considering the bacterial nature of the disease, antiseptics form one necessary class of agents for treatment. Oxygen in the form of an abundance of pure air is always indicated. The sick-room should be kept at an uniform temperature and the air moistened with spray, either of simple steam vapor of lime, of carbolic acid, corrosive sublimate, listerine, muriate of ammonia, or cocaine. Thymol, eucalyptus or quinine, may be used in this form. The following formulæ for use with the spray are recommended:

R.	Acidi carbolic cryst.	3 grs.	
	Sodii bi-boratis		
	Sodii bi-carb.	aa	20 grs.
	Glycerinæ		1 oz.
	Aquæ		1 oz. M.

R.	Thymol	15 grs.	
	Alcoholis	3 dr.	
	Glycerinæ		$\frac{1}{2}$ oz.
	Aquæ		34 oz. M.

The inhalation of a few drops of ether or chloroform is recommended when the paroxysms are violent. Of emetics, alum is thought to be the best, a quarter or half a teaspoonful being given with syrup or honey, and repeated if necessary. In the mean time the child may be placed upon its stomach, with the head lowered. Of nervous sedatives, belladonna is the best for this trouble, and may be given in suitable doses of the tincture, or in the form of the sulphate of atropia,  $\frac{1}{200}$  of a grain at a time, increased until the pupils are dilated. The bromides of sodium, ammonium, or potassium may also be given, and in many cases chloral is very useful. Of the latter, for a child one year old, two grains may be given at bed time. Of

quinine, a grain may be given several times during the day with good effect. The foregoing list may be increased by the addition of pilocarpine, benzoate of sodium, salicylic acid, sulphur, cantharides, calomel, and soda, etc. Counter-irritation is an important measure, a mixture of croton oil, oil of amber, and oil of cloves, mixed with sweet oil, and rubbed upon the neck or chest, being recommended. The bowels should be kept freely open, heat applied over the lungs if they appear to be implicated, and a nourishing diet with a suitable quantity of stimulants administered.—*Archives of Pediatrics*.

**INCONTINENCE OF URINE IN CHILDREN.**—Eustace Smith gives the following in his recent work: "Of medicines which diminish irritability, belladonna takes the first place, but it is important to be aware that this remedy to be effectual, must be given in full doses. Children have a very remarkable tolerance for belladonna, and will often take it in surprising quantities before any of the physiological effects of the drug can be produced. In obstinate cases of enuresis the medicine should be pushed so as to produce dilatation of the pupils, with slight dryness of the throat. In children of four or five years of age, it is best to begin with twenty-five or thirty drops of the tincture of belladonna, given three times in the day, and to increase the dose by five drops every second or third day, of course watching the effect. Ergot is another remedy which is often very successful. For a child of the same age, twenty drops of the fluid extract may be given several times in the day.

Bromide of potassium, benzoic acid (dose, five to ten grains) and benzoate of ammonia, digitalis, borax, cantharides, camphor and chloral have all been recommended as specifics in this complaint. Sometimes a combination of several drugs seems to be more effectual than one given alone. I have lately cured a little girl, aged four years, who had resisted all other treatment, with the following draught given three times in the day:

R Tinct. belladonna.....gtts. j.  
Potas. brom.....grs. x.  
Infus. digitalis.....5 ij.  
Aquam ad.....3 ss.  
M. Ft haustus.

When the incontinence continues in the day as well as at night, strychnia should be combined with the sedative, so as to give tone to the feeble sphincter. In these cases, too, cauterization of the neck of the bladder, with a strong solution of the nitrate of silver (℞—3 j. to the ounce of water) has been found successful."

**VALUE OF "THE DIAGONAL LINE" IN THE DIAGNOSIS OF DISTENSION OF THE GALL-BLADDER.**—John W. Taylor, F.R.C.S., Birmingham and Midland Hospital for Women, says: In an article on

cholecystotomy in the *British Medical Journal* of January 31, 1885, I wrote as follows: "An important aid to diagnosis will, I think, be found in recognition of the diagonal line in the direction of which the gall-bladder enlarges. This is to be traced from the normal position of the larger end of the gall-bladder (near the tip of the cartilage of the tenth rib on the right side) to the opposite side of the abdomen, crossing the middle line slightly below the umbilicus."

Since writing the above, I have had some additional opportunities for testing the value of this aid to diagnosis. On February 15, 1885, I was asked to see a case of abdominal tumor by my friend Dr. Drury. There was no jaundice, and but little clinical history to be obtained in the limited time at my disposal. Finding, however, a well defined, hard, but rather resilient tumor, the longer axis of which exactly corresponded to the diagonal line described, I had no hesitation in diagnosing the case to be one of distension of the gall-bladder.

This opinion (in which Dr. Drury concurred) was considered erroneous by another surgeon of large experience, who saw the case subsequently; and, as the chief reason for my opinion was the sign which is the subject of my communication, the case became of some special importance to me as a test.

On March 26th Mr. Tait operated. The tumor proved to be a distended gall bladder; and a large number of calculi were removed from it, two of these being of enormous size.

I should like to again draw the attention of the profession to this diagnostic line, as I believe it to be trustworthy and useful.—*British Med. Jour.*, April 11th.

**BELLADONNA INJECTION FOR GONORRHOEA.**—Some thirteen years ago an officer on board one of the vessels of the Indus Steam Flotilla consulted me for a bad gonorrhœa with intense pain on micturition, and intolerable chordæ at night. The case was urgent, and I ordered an injection composed of seven ounces of water, an ounce of mucilage acacia, twenty grains extract of belladonna, and twenty grains of sulphate zinc, a teaspoonful to be injected immediately before and after micturating, and a similar amount the last thing at night; great care to be used in passing the injection fully down as far as the pain is most intense. An ointment of spermaceti and mercurial ointment, four drachms each, and ten grains extract belladonna, ten grains powdered opium, as a paste to be smeared along the perineum and around the crura penis at night. Patient left next morning, having had no chordæ that night, and the pain of micturition disappeared by using the injection. Within a week there was complete cure. From that time I have had numerous gonorrhœal cases of every type and stage, and without exception with unfa-

ing success. Not long since a shop assistant presented himself with a bad gonorrhoea, high fever, inflamed testicle and chordee at night. With the application of the belladonna and opium ointment the chordee did not appear, and in four days after using the injection the running ceased, but after the first application the pain and running were much lessened. A suspensory bandage was worn, and with the daily use of the mercurial and belladonna and opium ointment the patient was quite well in three weeks. Patients have always stated that it is the injection, and not the ointment, which stopped the chordee. I have tried the anodyne treatment in various classes of people, from the dissipated paupers of the Eastern bazaars to the well-fed *roue* in the West; in the acute and in the chronic and gleet stages; in first attacks, and in those making one of a series; and in cases complicated with inflamed testicles and chordee; and I have no hesitation in saying that I have not witnessed anything to contra-indicate it nor to mitigate its success.—John Roche, M.D., in *Medical Press*.

**THE INJECTION OF HOT OR COLD WATER IN UTERINE HÆMORRHAGE.**—Dr. Schwarz relates a case of post-partum hæmorrhage which was controlled temporarily by an injection of water at a temperature of 120° F., containing two and a half per cent. of carbolic acid. The bleeding began again, however, and could not be arrested by further hot-water injections. A trial was then made of ice-water with perfect success. In other puerperal and non-puerperal cases, after failure with hot water, the author obtained most satisfactory results with cold injections. Dr. Graefe has also had several cases in which he found cold irrigations to answer the purpose after hot water had failed. He regards the styptic action of hot water as due not only to the swelling of the tissues which it causes, but also to a certain degree of muscular contraction in the uterine walls. The former is not sufficient in itself to arrest the hæmorrhage unless aided by muscular contraction. When cold water irrigations follow those previously made with hot water, strong contractions of the uterine muscles are excited, but the oedematous swelling caused by the hot water can not be so rapidly overcome, and hence the two conditions most favorable for arresting the hæmorrhage are present. In the same way when hot injections follow cold ones, the irritation to the muscular tissue remains, and to it is added the swelling of the tissues above mentioned. If only one be used, Schwarz prefers the cold water, as having the advantage of absolute safety. Hot water, if too hot, may cause a paralysis of the uterine muscular tissue, and if not hot enough will only increase the hæmorrhage. If a trial with one temperature be unsuccessful, the use of the opposite will almost certainly control the bleeding.—*Schmidt's Jahrbucher*, No. 7, 1884; *Med. Record*.

**SWALLOWING OF ARTIFICIAL TEETH.**—Artificial teeth have probably been often swallowed. Too hard for digestion and not provided with sharp-pointed edges, as a rule, they cause very little inconvenience. More dangerous is the swallowing of whole sets, as in such a case a plate, with all its hooks and pointed edges, has to pass through the pylorus and the ilio-cæcal valve. If it were possible, after such a plate has been inadvertently swallowed, to send some substance after it that could envelop the pointed and "hooky" plate with a material which might remove the sharp points, the greatest danger would be removed. But thus far this substance has been a desideratum unfulfilled. In the April 13, 1885, number of the *Deutsche Med. Zeit.*, however, we find a communication which, on account of the ingenuity of the procedure, and of its complete effect, is highly interesting and deserves further dissemination through the columns of the *Medical and Surgical Reporter*.

A dentist named Geisselbrecht, in Fürth, was sent for one night by a servant girl, who, during sleep, had swallowed her artificial teeth. The set consisted of a rubber plate with four canines and two bicusps, which plate was attached by the aid of gold clamps to the natural teeth. On examination, the neck of the girl was found to be swollen and painful to the touch in the region of the larynx. The examination of the pharynx gave no result; the set had disappeared; but with the use of the œsophageal sound it could be felt. But as the plate had already passed too deeply, there was no prospect of its being extracted, and G. pushed it with the sound into the stomach through the cardiac orifice.

Now comes the interesting part of the procedure. That the plate might pass on through the intestinal canal without injuring the latter, G. induced the girl to swallow a lot of cotton thread (spool cotton), which was first cut into small pieces and incorporated in the white of an egg beaten to snow. The intention was to have the threads steeped into the white of the egg, wrap themselves around the sharp points of the plate and thus prevent their injuring the intestines.

The result has been a brilliant one; four days later the girl brought the ominous plate, and the latter was found to be completely enveloped, over-spun, as it were, by the cotton threads. The patient said that she had no pain, or any other inconvenience either, while the plate was resting in the bowels or during its passage out.—*Med. and Surg. Reporter*.

**THE TREATMENT OF CHOLERA.**—The current number of the *Practitioner* contains the concluding paper of the interesting series that have been published in that journal by Drs. Lauder Brunton and Pye-Smith, in the course of which they have dis-

cussed the present knowledge of the pathology of cholera. Speaking of the treatment of the disease, they divide remedies into five classes: of these, three contain remedies which act on the intestine. They are—1. Those which are likely to have an antiseptic action on the intestine by destroying any organisms there present, such as carbolic acid and its allies, sulphurous acid, nitro-muriatic acid, hyposulphites, permanganates, chlorine, chloralum, turpentine, salts of copper, boracic acid, calomel, and corrosive sublimate. The cholagogue action of calomel is thought to be of service by inducing indirectly the antiseptic action of bile. 2. Those remedies which will tend to remove the cholera poison, whether it consists of living organisms or of some chemical substance, exemplified by the treatment by castor oil and other purgatives. 3. Those remedies which will counteract the effect of the poison upon the intestinal canal, as opium, morphia, ice water, belladonna, cannabis indica, chloroform, chloral, carminatives, and astringents. 4. Remedies which will tend to eliminate the poison from the system, as copious draughts of water (as diuretic) and purgatives. 5. Those remedies which will counteract the effects of the poison—viz., intravenous injection of saline fluids and other substances, and various measures to restore the circulation by acting upon the skin. In dealing with the premonitory diarrhoea, Cantani's method of injections, by means of the long intestinal tube, of laudanum and tannic is described. The authors consider that Ferrán's results of inoculation are more favourable than could have been expected, and point out the following as "directions in which further researches after a remedy for cholera are most likely to prove successful":—"1. The discovery of an antiseptic which will destroy pathogenic organisms in the intestines and prevent the formation of the cholera poison, while they are not themselves poisonous. Corrosive sublimate is a sufficiently powerful antiseptic, but it may itself prove poisonous to the patient as well as to the pathogenic organisms. It is possible that amongst the members of the aromatic group of bodies substances may be found having the desired properties. 2. The discovery of some substance which will antagonise the action of the cholera poison after its absorption. As a preliminary step in this direction further experiments are needed in the nature and action of alkaloidal substances obtained from cholera dejecta, as well as from artificial cultivations in various media and under various conditions, electrical and otherwise. 3. Observations on the effect of stimulation of the mesenteric plexus by currents passed through the uninjured abdomen in poisoned animals and in patients suffering from the disease."—*Lancet*.

**TREATMENT OF SCROFULOUS NECK.**—Dr. Clifford Allbutt, in a recent lecture, affirms that the

chronic enlargement of the glands of the neck, known as scrofulous neck, is secondary to irritation in the associated mucous membranes, and absorption therefrom; the chief of these being the mouth and throat, and the next in order the nasal, aural, and ocular surfaces; and sometimes from irritation upon the skin of the face and head. Speaking of the treatment of these cases, the author says that a residence at Margate, together with careful dieting and nursing, is the best means of cure in cases which are not far advanced. The cautious use of mercury, such as the solution of the bichloride, with tincture of iron, is very good, unless the inborn frailty be very marked; and iodides with iron are likewise valuable. External applications should be used with caution. So soon, however, as the glands become adherent, either to each other or to the surrounding tissues, then it is most desirable to call in the surgeon, and to extirpate every caseous gland or portion of a gland. Mr. Teale has devoted much time and has had great experience in operating on these cases, and it is due to the combined exertions of Dr. Allbutt and Mr. Teale that numerous cases have been restored from a state of misery to enjoy a life of comparatively good health. The scar remaining after the operation is small, and after a year or two not very noticeable, provided the drainage be not kept up too long; it is better to risk a second operation than to keep the drainage-tube in for too long a period.

**DIFFERENTIAL DIAGNOSIS OF SIMPLE AND TUBERCULOUS MENINGITIS.**—In an analysis of a number of cases of meningitis occurring in the Children's Hospital at Stockholm, Dr. O. Medin endeavours to formulate the points of difference in the tuberculous and simple forms of the disease. Tuberculous meningitis attacks only those children already suffering from tuberculosis of other parts, while simple acute meningitis occurs usually in previously healthy individuals. The former manifests its onset by convulsions, frequently strabismus, and dilatation or contraction of the pupils. Vomiting is frequent at the commencement, diarrhoea is the usual condition, and constipation is rare. The abdomen is never flat. The simple form begins with somnolence, twitchings, sudden changes of color in the face, and hyperesthesia. More frequently than in the tuberculous form we meet with the hydrocephalic cry, and a paralysis limited to the arms or to the face. The tuberculous variety is always fatal in its termination.—*London Practitioner*.

**TREATMENT OF VARICOCELE BY EXCISION OF A FOLD OF THE SCROTUM.**—At a recent meeting of the Académie de Médecine, Horteloup recommended a plan of operation which he has practiced for several years with success. He pushes the



testicles upwards, and seizes with a long pair of forceps a fold of scrotum containing the plexus of the spermatic veins. Deep sutures are passed immediately in front of the forceps and fixed by leaden tubes; a row of superficial sutures is then placed a little nearer the edge of the fold, which is afterwards excised. The superficial sutures are tied, and an antiseptic dressing is applied to the wound. M. Horteloup has performed this operation in eighteen cases without any serious accident, and expresses himself much pleased with the ultimate results.—*London Med. Record*, April.

**DIAGNOSIS OF GONORRHOEA IN THE FEMALE.**—Martineau, at a recent meeting of the Paris Obstetrical and Gynecological Society, stated a most important fact by which specific can be distinguished from simple vaginitis. It depends upon this that in the specific form of the disease the pus is always acid, while in the simple it is alkaline. It is very easy, therefore, to decide by a piece of litmus paper as to whether a woman is or is not suffering from gonorrhoeal inflammation.

This sign will prove of value, too, in determining, when rape has been committed, whether the person committing the crime was affected with gonorrhoea, for then the vulvitis would be characterized by an acid discharge, while in the simple form of the disease the discharge is alkaline.—*Med. News*.

**ACUTE ABSCESS.**—Prof. S. W. Gross says it is a mistake to apply a poultice to an abscess after its contents have been evacuated. The endeavor should be to prevent and not encourage the formation of pus. To do this the cavity of the abscess should be syringed out with a 1 to 1000 solution of mercuric bichloride, and the walls brought together by compresses and bandage, and union allowed to take place by granulation. If the abscess be of large size a drainage tube should be left in for a couple of days until the serous oozing has been reduced to a minimum. The tube should then be taken out and the walls brought close together. If the healing process be delayed by the development of flabby cedematous granulations they can be stimulated to healthy action by the injection of a three per cent. solution of carbolic acid or the application of chloride of zinc gr. iij., aqua 3j.—*Med. Bulletin*.

**TREATMENT OF SPERMATORRHOEA.**—Dr. Nowatschek reports in *Schmidt's Jahrbucher*, January, 1881, a case of spermatorrhoea consequent on typhoid fever, the diagnosis resting on the presence of spermatozoa in the fluid which was constantly oozing from the urethra. Iron, quinia, and cold applications to the genitals were tried in succession with some success, but a cure was not accomplished. Lupulin, camphor, and bromide of potassium were

without effect. Atropia was then employed, and the patient was completely cured in five days. The author cites a second case where he was equally successful with the hypodermic injection in the perineum of a one per-cent. solution of atropia.—*Four. de Med. de Paris*.

**ANTIPYRIN.**—This new antipyretic, is now advanced to the position occupied by quinine, salicylic acid, etc. Dr. A. C. Girard, assistant surgeon in the U. S. Army, in the *Medical News*, speaks very positively in regard to its usefulness as an antipyretic. He says it reduces the temperature without evil concomitant; the fall of temperature begins one or two hours after ingestion of the remedy, and its effects last from seven to twelve hours. It does not seem to shorten the disease for which it is given, but surely lowers the temperature, and thus prevents the rapid waste consequent upon the high temperature. The dose advised is from fifteen to thirty grains, or even more.

**A METHOD OF TREATING PRURITIS ANI.**—A correspondent of the "*British Medical Journal*" suggests the following plan of treating this distressing affection: Wash the external parts well with warm water, and inject a small amount of water into the rectum. Then introduce a ball of cotton saturated with a lotion consisting of:

Carbolic acid.....	20 grains;
Laudanum.....	4 drachms;
Dilute hydrocyanic acid.....	2 "
Glycerin.....	4 "
Water, enough to make.....	4 ounces.

The pledget should be removed before defecation, and a fresh one introduced after the act.—*N. Y. Med. Journal*.

**RAPID BLISTER.**—It is sometimes desirable to produce a small blister quickly. For this purpose nothing is better than concentrated water of ammonia (*aqua ammoniac fortior*). Put a few drops of it in a watch crystal, or any receptacle of the sort, cover it with a pledget of absorbent cotton, invert on the spot to be blistered, and press closely. In half a minute or so a red circle will appear on the skin around the edges of the confining vessel. It is an evidence that vesication has taken place, and the blistering material can be removed. The blister should be treated in the same manner as one obtained from cantharides.—*Southern Clinic*.

**COD-LIVER OIL AND LIME-WATER IN SCALDS OF THE THROAT.**—Palmer ("*Practitioner*"), referring to the frequency with which young children are scalded by drinking from the spout of a teakettle, speaks highly of the therapeutical value of teaspoonful doses of lime-water and cod-liver oil (equal parts). In a severe case treated by him the patient received a teaspoonful of this novel "car-



ron-oil" every hour. The pain was promptly relieved, the child was soon able to swallow, and within a few days recovery was assured. The writer does not give a very satisfactory explanation of the *modus operandi* of the remedy.—*N. Y. Med. Four.*

**SUPPORTING THE PERINEUM.**—In the *Clinique d' Accouchements*, at Paris, Depaul in one of his last lectures said: "I never support the perineum; I am contented with supporting the head of the fœtus and preventing it from emerging too suddenly." Often, when the perineum has been supported, it has been found on withdrawing the hand that a rent has been made in the perineum by the hand itself. For this reason Depaul said, support the head, but leave the perineum alone.—*N. Y. Med. Times*, April.

**CHRONIC DYSENTERY.**—Prof. Da Costa finds sulphate of copper, gr.  $\frac{1}{2}$ — $\frac{1}{4}$ , four times a day, combined with opium, to be very effective in chronic dysentery. Other remedies he finds useful are bismuth, especially in children; nitro-hydrochloric acid, zinc sulphate, argentic nitrate, iron sulphate, or Monsell's solution (gtt. iij. -v.), or solution of the nitrate (gtt. xx.-xxx.) All except iron should be combined with opium. When other things fail, small blisters over the spot of greatest soreness sometimes do good. The diet should contain no starches, fruits or vegetables.—*Coll. and Clin. Record.*

**TREATMENT OF ECLAMPSIA BY WARM BATHS.**—Breus has given in the *Archiv für Gynækol.*, Band xxi., No. 1, the result of his observations in seventeen cases, two of which ended fatally. He recommends putting the patient in a bath at 38° C., and to raise the temperature of the water gradually until it reaches 41° C. After that, the woman is wrapped up in blankets, and abundant perspiration sets in. When albuminuria exists during pregnancy, a course of warm baths may prevent the occurrence of convulsions at the time of confinement.—*London Med. Record*, April.

#### ECZEMA OF THE GENITALS.—

R Potassii chloratis 1.50 gm.  
Vini opii 2.50 gm.  
Aquæ puræ 1 litre.

Apply on a compress. To be preceded by a warm sitz-bath or by mild cataplasms if there is a certain degree of attendant inflammation.—(*La France méd.*)—*Phila. Med. Times*, April 18th.

**PRURITIS OF PREGNANCY—SULPHUROUS-ACID LOTION.**—Dr. Powell, Peckenharn, writes in answer to a query: Presuming "A Member's" patient is not diabetic, I would suggest that she apply to the

parts affected a lotion of sulphurous acid in warm water (half ounce to the half pint), the results of which I have uniformly found successful.—*Brit. Med. Four.*

**APPLICATION IN ORCHITIS.**—The following formula is highly endorsed as a local application in orchitis:

R Iodoformi 3 j.  
Thymol gr. iv.  
Vaseline 3 j.

M.—To be applied greased on linen.

—*Med. World*, April.

**EXTRA-UTERINE PREGNANCY.**—In a recent number of the *Brit. Med. Four.*, Mr. Lawson Tait reports three cases of tubal pregnancy, with consequent rupture of the tube, in which laparotomy was performed successfully. Mr. Tait has now saved eight women out of nine in whom a similar condition existed. This is a remarkable record, and we do not know which most to admire, the accuracy of the diagnosis or the promptness with which the emergency was met. In Mr. Tait's opinion all cases of extra-uterine pregnancy are of the tubal variety.—*N. Y. Med. Four.*

**HEPATIC COLIC.**—In a case of hepatic colic with a tendency to the formation of biliary calculi, Prof. Bartholow prescribed:

R Sodii cholat gr. xxx.—xl.  
Extract, nucis vomicæ gr. ijss.

M.—Fiant pil. x. Sig.—One pill ter in die. The cholate of sodium will help to keep the bile in a soluble condition.—*Med. Bulletin*, April.

**DYSPEPSIA.**—The following will be found excellent in cases of dyspepsia either chronic or acute: R Elix. pepsin 3 iss., bismuth sub. nit., 3 i., fl. ext., hydrast, canadensis, 3 iss., Tr. lavender co., syrup. simplex, equal parts, q. s. ad., 3ij. M. Sig.—Teaspoonful 3 three times a day before meals.—*Med. World.*

WHENEVER a case of scrofulous disease was presented at his clinic, in the person of a child *whose father had been in the army*, the late Prof. Gross, asking no further questions, would turn to the class with the single, but significant, remark, "*Specific, gentlemen!*"

**TRACHEOTOMY** in diphtheria saves but few persons who take the disease in severe epidemics, according to Dr. Jacobi. This opinion is founded upon fifty consecutive unsuccessful tracheotomies during a period of two years.

DR. LEWIS A. STIMSON has been elected Prof. of Anatomy in the University of the city of New York, to succeed the late Prof. Darling.

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

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*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## PHYSICIANS' WORRIES.

It would be hard to name a class of men more the victims of worry than medical men. It is not to be presumed that this arises from anything inherent or exceptional in the constitutional make-up of medical men. The young men who come up from every grade of society to learn the mysteries of medicine, are as free from the cares of life, and as buoyant in temperament, as mankind produces. Indeed, we venture to remark, that for unselfishness, present enjoyment of life, and freedom from the forebodings of the ills the morrow may bring, they stand pre-eminent. How then does it come, that so large a number in after life become unhappy, care-worn, and wind up their mortal career at a much earlier period than men of other walks of life? The very fact of medical men dying off, before their time, so to speak, goes a long way to support the commonly-made assertion that the physician leads a life of toil and worry. Of course we all know that there are many exceptions. There are those who, however much they toil, do not worry—and are always cheerful and contented amidst even the most unfavorable environments. Amongst these we may safely class all the octogenarians dead or living, for it is rare indeed that the man who is bowed down from early manhood by a load of anxieties and troubles reaches even his allotted three-score and ten years, no matter what his calling or circumstances in life. It is said, and said

truly as regards mental work, that it is worry and not work that kills. True, the work of the busy physician is anomalous inasmuch as severe physical exertion has to be borne along with the mental strain inseparably associated with the performance of duties, in their very nature weighty and critical, and hence demanding, almost constantly, the full exercise of the intellectual faculties. In this respect the practice of medicine, we believe, is unique. This of itself would, to some extent, account for the anxieties which perpetually harass the conscientious physician, and tend to make him short-grained and grey-haired before his time.

But the struggle for existence is by far the largest factor in the medical man's troubles. As he looks on his wife and children and reflects what little provision he has hitherto been able to make for their future wants; or, worse still, finds himself unable to meet present demands, and yet is obliged to maintain himself and family in a manner becoming their station,—he naturally begins to feel uneasy. "The narrower the pit the fiercer the fight," and the knowledge that others are making a dead set on what is barely enough for himself, is a fruitful source of worry, and to most natures unavoidably so. Under such circumstances he feels it imperatively necessary to guard his little patronage with the utmost care and watchfulness, sparing neither physical nor mental effort to ward off the approaches of those whom necessity compels him to regard as intruders and enemies. And thus has it come to pass, in all civilized countries, that the majority of the members of a humane and noble profession are so hotly engaged in a competition, involving no higher issues than bread and butter, as to rob them of needed rest and recreation, induce feelings of jealousy and enmity, culminating in a state of hopeless, chronic worry. We must not omit to mention that a good many, "blessed with enough and to spare," may also be placed in the above category. It is a pity it should be so, but we all know that our profession has its mercenary members like all other callings, and not a few either. Instead of lending a helping hand to the beginner, or to an unfortunate or distressed brother, they are found engaged in a perpetual war of extermination, waged on the Darwinian theory, that the fittest alone has a right to survive!

It is a subject of common remark, that medical men are more than usually sensitive in the matter

of criticism. This is probably true, but there is a reason for it, and that is, that his reputation is the medical man's whole stock-in-trade. When that is wantonly assailed, as too often happens, but few can stoically remain unmoved. This is all the more difficult, because such adverse criticism usually comes from persons wholly incapable of judging in medical matters, and generally is uncalled for, ungenerous, and foundationless. No calling is so much exposed to the assaults of the ignorant and malicious, and no form of slander is so difficult to disprove, or to arrest on its rounds, as that which falls to the lot of the physician.

We might also refer to the nature of the work the physician has to perform. His mission is not to the gay and happy, but to the downcast and miserable. His path lies through sickness, suffering and death, and the gloom which overhangs such scenes. It would be easy to name other troubles peculiar to our calling, but let this suffice for the present. While most of our worries are inherent to our duties, it must be confessed that they are greatly aggravated by our own imperfections, and instead of unduly magnifying them, it should rather be our aim to reduce them to a minimum, and heroically resolve to endure what cannot be amended. But the picture has another and brighter side. Medical men are messengers of "peace and good will to men," in a less high degree of course than spiritual messengers, but such they are nevertheless. The binding up of wounds, the alleviation of pain, the removal of disease and restoration to health, hope and the enjoyments of this life, is a mission so beneficent and exalted as to afford, in quiet moments, much joy and satisfaction to all who engage in it, and rightly apprehend its true nature. Were more of this spirit to prevail and less of the mercenary, many of the ills of which we complain would disappear, and the profession of medicine would be greatly elevated in the estimation of its membership and the public generally. But such a thought is too Utopian for serious mention in the present utilitarian condition of society.

Charity begins at home, and every man owes a duty to himself and his household. Of the duties thus imposed but few are as important as the cultivation of a cheerful, hopeful disposition. There is wealth, health and happiness in it. To do this successfully, the medical man needs helps. Let

him have some hobby, some means of diversion to lift him for a few hours, at least, out of his well-worn ruts. He should not hesitate, nor consider such time lost, to take a holiday now and again. The freshness and vigor of both body and mind acquired more than compensate for the time and money spent. We owe to our patients the sunshine of a cheerful and happy manner. The sick need encouragement, and all the inspiration to be derived from a hopeful disposition and buoyant spirits. Let the doctor not withhold these potent adjuncts when called upon to prescribe. They are not only cheap but marvelously efficacious as well.

#### ONTARIO MEDICAL COUNCIL.

The first meeting of the newly elected Council of the College of Physicians and Surgeons of Ontario was held in this city on the 13th ult., and following days. All the members were present, and the business of the College was promptly and faithfully attended to. Dr. Bergin, M.P., of Cornwall, was elected president, and Dr. Douglass, of Port Elgin, vice-president. The secretary and treasurer were re-appointed, and many new names were added to the various standing committees. Some interest was taken by members in regard to those students who went to the North-West as dressers and were thereby prevented from taking their primary examination. After some discussion and supported by the opinion of the solicitor, the Council very wisely decided to allow the students so situated their primary examination. The curriculum was not disturbed, save in one respect, viz., the placing of arts graduates in the same position as mentioned in last year's announcement, *three* years' medical study only being required, instead of four as was proposed last year. In the matter of registration, it was decided to make the registration fee \$25, instead of \$10 as at present. This was deemed necessary, owing to the loss of fees sustained in consequence of a number of students qualifying in Great Britain, who were admitted to registration on their return on payment of the small fee of \$10, while those who took the Council examinations were required to pay \$60. The fees for the primary and final examinations will be correspondingly reduced, so that the fees for those who take the Council examination will be the same as heretofore. The examining board of last year

was re-appointed, no change being considered advisable at present. It is gratifying to observe that the spirit of intermeddling with the regulations of the Council, so much in vogue a few years ago, has given place to a settled determination to make changes only when they appear after due consideration to be essentially necessary in the interests of the college. With regard to the site for the college building, it has been suggested that the Council retain the present site on the corner of Bay and Richmond streets, and erect a large building, three storeys in height; the lower storey to be rented for business purposes, and the upper storeys reserved for the use of the college. The proposal seems a very good one, and a committee has been appointed to consider the whole matter.

#### NEW INTERPRETATION OF THE CODE.

A committee of the American Medical Association was appointed last year, consisting of Drs. N. S. Davis, Chicago; Austin Flint, sr., New York; H. F. Campbell, Augusta, Ga.; A. P. Garnett, Washington; and J. B. Murdock, Pittsburgh; to report on the interpretation of certain clauses of the "code" which have been differently understood. The following liberal interpretation by the eminent men above-named, was received and adopted by the Association at its recent meeting in New Orleans, and has met with the approval of the profession generally:

*Whereas*, Persistent misrepresentations have been and still are being made concerning certain provisions of the Code of Ethics of this Association, by which many in the community, some in the ranks of the profession, are led to believe its provisions exclude persons from professional recognition simply because of difference of opinion or doctrine; therefore be it

*Resolved*, That Clause 1, Article IV., in the National Code of Medical Ethics, is not to be interpreted as excluding from professional fellowship, on the ground of difference in doctrine or belief, those who in other respects are entitled to be members of the regular medical profession, neither is there any other article or clause in said Code of Ethics that interferes with the exercise of the most perfect liberality of individual opinion and practice.

*Resolved*, That it constitutes a voluntary disconnection or withdrawal from the medical profession

proper to assume a name indicating to the public a sectarian and exclusive system of practice, or to belong to an association or party antagonistic to the general medical profession.

*Resolved*, That there is no provision in the National Code of Medical Ethics in any wise inconsistent with the broadest dictates of humanity, and that the article of the Code which relates to consultations cannot be correctly interpreted as interdicting, under any circumstances, the rendering of professional services whenever there is pressing or immediate need of them; on the contrary, to promptly meet the emergencies occasioned by disease or accident, and to give the helping hand of assistance without unnecessary delay is a duty fully enjoined on every member of the profession, both by the letter and spirit of the entire Code, but no such emergencies or circumstances can make it necessary or proper to enter into professional consultation with those who have voluntarily disconnected themselves from the regular medical profession in the manner indicated by the preceding resolution.

#### MALPRACTICE SUITS.

Two cases for alleged malpractice were tried during the past month in this city. The first was an action to recover \$10,000. The parties were John Johnston, of Midland, and Dr. Kidd, of the same place. On June 21st, 1884, the plaintiff's son, twelve years of age, stepped on a piece of broken glass and wounded the arch of his foot severely. Dr. Kidd was called in, and, as there was no hemorrhage at the time, he stitched up the wound and told the parents to send for him if anything untoward occurred. This they did not do. It bled on several occasions up to the 13th of the following month, but not until then was the doctor sent for. The plaintiff claimed that the doctor did not tie the artery, that the foot was bandaged too lightly, and in consequence mortification set in and part of the foot sloughed away, which will necessitate amputation. After a few of the plaintiff's witnesses were examined, it became evident that there was no cause of action against the doctor, and Mr. Osler, Q.C., who appeared for the plaintiff, threw up his brief.

In the second case the plaintiffs were Jas. H. McQuaig, a farmer in Pickering township, and his

wife, who sought to recover damages from Dr. Eastwood, of Whitby, claiming that in November, 1884, during Mrs. McQuaig's confinement and subsequent illness, he treated her negligently and unskilfully. This trial occupied two days, and a number of witnesses were called on both sides. The principal medical evidence on behalf of the plaintiff was the plaintiff's brother-in-law, Dr. Whiteman, of Shakespeare, supported in part by that of Dr. Warren, of Brooklin. On behalf of the defendant, several medical gentlemen in Toronto were examined, all of whom in the main approved Dr. Eastwood's treatment of the case. The counsel for the plaintiff, Mr. Lount, moved twice during the trial to secure a non-suit, and although the judge ruled against him, he finally charged the jury strongly for the defendant. Notwithstanding the judge's charge, however, the jury brought in a verdict for the plaintiff, assessing the damages at \$350. The case will be appealed.

#### ONTARIO MEDICAL ASSOCIATION.

The fourth annual meeting of the Ontario Medical Association was held in London on the 3rd and 4th ult., the President, Dr. Worthington, in the chair. There was a large attendance of members present, and upwards of thirty papers on the programme. It therefore became necessary on the second day to divide up into sections, one on medicine and another on surgery and obstetrics. The discussions, both in the general meeting and in the sections, were more than usually varied and interesting. None of the papers were passed over without a satisfactory discussion, and much information of value to the members was elicited. The interest in this young and vigorous Association seems to be increasing yearly. The wisdom of the departure from the former method of preparing reports on medicine, surgery and obstetrics, which were usually taken as read, was well seen in the admirable papers read by the chairmen of the different departments, and the very interesting discussions which followed. We would still further suggest that, inasmuch as it is now necessary to form the Association into sections, that the chairmen of the sections should be elected at the same time as the other officers of the Association, so that the Association may have the benefit of a carefully prepared address in each department at the open-

ing of the sessions. We trust this matter will not be overlooked at the next meeting of the Association. We are also pleased to announce that the next meeting will be held in Toronto. This is, undoubtedly, the most central place in which to hold the meetings. Owing to the numerous railway lines, this city is within easy reach of the greatest number of members, and adding to these the large contingent in the city itself, there is always certain to be a large attendance. Without in any way desiring to speak slightly of the cities in which the last two meetings have been held, we believe that it would be greatly in the interest of the Association if all the meetings were held in Toronto. The choice of Dr. Tye as President of the Association was a well-deserved compliment to an earnest worker and a zealous and worthy member of the Association. The Association has been thus far fortunate in the choice of its leading officers, and so long as such worthy men fill these honorable positions, we can confidently predict for it a grand future.

CANADA MEDICAL ASSOCIATION. — It will be remembered that it was decided at the last meeting of the Association to meet this year in Winnipeg. Owing however to the outbreak in the North-West, and the disturbed state of things generally, our brethren in Winnipeg have reluctantly decided to forego the honor of entertaining the Association this year. In consequence of this decision, and by the kind and pressing invitation of our worthy confrères in Chatham, Ont., the Association will meet there on the 2nd and 3rd of September, under the presidency of Dr. Osler. We confidently bespeak a large attendance, and can promise the members of the Association a right hearty welcome from our friends in Chatham.

CHLORAL HYDRATE IN EPILEPSY.—This valuable remedy is well known to the medical profession, but it may not be so generally known as it ought to be that it is sometimes of invaluable service in arresting epileptic fits, especially that form known as the status epilepticus. We have recently had some experience of its use in a case where all other remedies had failed, including inhalation of ether, chloroform, and amyl nitrite. A twenty grain dose immediately put a stop to the frequently-recurring attacks, and the patient made a good recovery from the seizure.

**GENERAL GRANT'S CASE.**—Latest reports in regard to the condition of Gen. Grant, would seem to indicate an improvement, but there is no evidence that the case is not hopeless. General Grant is able from his past military experience "to put himself in the place" of his medical attendants to good purpose. His reported remark to his physicians savors of true wisdom: "The doctors outside I am informed, are writing about my case and talking about it, and some of them seem to think they know more about it than you gentlemen do; but it is like a time of war, when the men at home think they know more about it, and how to do it, than the generals who are in the field fighting."

**URIC ACID CALCULUS OF ENORMOUS SIZE.**—The *Lancet* for May 2nd, 1885, gives the following particulars of one of the most remarkable calculi that the records of surgery furnish. It was removed by the high operation by Sir Henry Thompson, from a man aged sixty-two. The stone was of an oval form, of pure uric acid without any phosphatic incrustation whatever. It weighed 14 oz. avoirdupois (405 grammes), and measured  $4\frac{1}{2}$  in. long,  $3\frac{1}{4}$  in. wide, and  $2\frac{1}{8}$  in. thick. The operation was rapid, and performed without difficulty, and the patient's present condition is unusually good and promising.

**PEPTIC SALT.**—Dr. Prosser James describes, in the *Brit. Med. Journal* for May 16, 1885, a preparation of pepsin and chloride of sodium, which he calls "peptic salt," to be used as a condiment. The pepsin and salt are combined in such a way as to form a pepto-chloride, which prevents decomposition. He says: It may be ordered in prescriptions, if preferred, as sal-pepticus, or as pepto-chloride of sodium. Ten grains of the peptic salt will dissolve nearly 200 grains of hard boiled albumen, or two ounces of lean cooked meat. It may take the place of table-salt in the dyspeptic's dietary.

**NITRITE OF AMYL IN GOUT.**—A very important question has been recently raised by Dr. A. McDonald, of Liverpool, in the *Brit. Med. Journal*, regarding the elimination of uric acid by nitrite of amyl. He noticed that on several occasions the acidity of the urine was markedly increased after the administration of nitrite of amyl, and a deposit of uric acid crystals took place in the urine. It

was given in a case of puerperal eclampsia, in gout, and also by way of experiment, and in all the result was the same. The drug was given by inhalation, in four minim doses, every two hours.

**BURIED CATGUT SUTURES.**—In the *Brit. Med. Jour.*, May 2nd, 1885, will be found a paper by Mr. Kelly in which he advocates "buried sutures" in wounds, that is, suturing separately periosteum to periosteum, muscle to muscle, nerve to nerve, fascia to fascia, skin to skin, etc. The advantages claimed are that drainage is not then required, no spaces or pockets are left where blood or serum can collect, and that cicatrization is rapid, complete and perfect. He refers to a number of operations in all of which he says "the results have been all that sanguine hopes could expect."

**WHOOPIING COUGH.**—The following has been found of great service in the treatment of this affection, especially to prevent the night spasms.

R	Pot. bromidi	ʒ j
	Chloral hydrati	ʒ ij
	Tr. belladonnæ	ʒ ss
	Syr. Aurantii	ʒ j
	Aq. Cinnan	ad ʒ iij—M.

**SIG.**—A teaspoonful at bed time for a child one year old and increase according to age.

**USE OF THE MEMBRANES IN LABOR.**—In an article in the *Med. Jour. and Examiner*, Dr. Byford of Chicago, makes a strong plea for non-interference with the membranes during labor, or until they protrude through the vulva. The presence of the bag of waters he maintains favors gradual dilatation, serves to protect the parts from laceration, and prevents irregular contraction of the uterus. He regards it as strange that obstetric science should teach the deliberate breaking up of the simple process of nature and substitute an unnatural and artificial one.

**MUSTARD SPONGE.**—The latest method of applying a mustard poultice is by means of a sponge. The plaster is prepared in the usual way, the sponge is dipped into it, then wrapped in a soft handkerchief, and applied to the part. By simply warming the sponge again and moistening it afresh, it may be reapplied, the strength being perfectly preserved.

**LONDON MEDICAL SOCIETY.**—The London

Medical Society has been recently reorganized, and the following officers have been elected:—Dr. Beemer, President; Dr. Waugh, Vice-President; Dr. Payne, Secretary - Treasurer. Since the reorganization the attendance has been very good, and some very interesting and instructive papers read and discussed.

APPOINTMENTS.—Dr. Robert L. McDonnell has been appointed physician to the Montreal General Hospital vice Dr. Osler; Drs. Blackader and F. W. Campbell, assistant physicians; Dr. Jas. Bell, assistant surgeon; Dr. W. Gardner, gynecologist, and Dr. Major, laryngologist. Dr. M. McD. Seymour has been appointed surgeon and Dr. F. S. Keele assistant surgeon, of the Winnipeg Battalion of Infantry.

W. R. Warner & Co., of Philadelphia, have received the first premium at the World's Exposition, New Orleans, for great uniformity and solubility for their sugar-coated pills. This is the ninth world's fair prize which attests to their excellence.

The epidemic which has prevailed so extensively in and around Plymouth, Pennsylvania, and which was not at first fully understood, is now said by competent observers to be typhoid fever.

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### Books and Pamphlets.

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THE CURABILITY AND TREATMENT OF PULMONARY PHTHISIS, by S. Jaccoud, Paris. New York: D. Appleton & Co. Toronto: Williamson & Co.

The title of this book is certainly very attractive. The practitioner or student who reads of the curability of intermittent fever by quinine, certain skin affections by arsenic, gout by colchicum, syphilis by mercurials, or whooping-cough by resorcin, may be led to expect that he will find in Jaccoud's treatise on pulmonary phthisis a therapeutic pearl of incalculable value in the control of a malady which has hitherto resisted all the weapons of the pharmaceutical armoury. He will therefore read the book with very sanguine expectations, but when he has reached the end of it he may wonder how it has been that the cures related have fallen very far short of his fond anticipations. We are told that "exceptions prove the rule," but this does not signify that they constitute the rule. That Jaccoud's treatment

of pulmonary phthisis has been, in his hands, *exceptionally* successful, it would be very indecorous to deny; yet when the reader summarizes results, he will most probably find that of the entire category of the cases of this disease, the percentage of cures, even including the shadowy class designated "relative,"—that is, temporary—is mournfully small. The author distinguishes three "varieties of phthisis:—the hereditary, the innate and the acquired form." "Of these," he tells us, "the hereditary form, from the mere fact of its being hereditary, offers the least prospect of recovery." It probably consists with the experience of the majority of practitioners, that this form represents a very large percentage of the whole number, and we fear it has very seldom been the good fortune of any physician to secure the cure of an hereditary case; and if so, the field for the achievement of success must be but limited—far too limited, indeed, to warrant the use of the term "*curability*," unless in a mournfully restricted signification. The term "*innate*," in contraposition with "*hereditary*," seems to us rather inappropriate. Innate literally is equivalent to inborn, ingenerate, inherent, not adventitious. Are not all hereditary diseases such? But it is right to allow the author to speak for himself, which he does in the following words: "Innate phthisis, which must not be confused, as I have already said, with the hereditary form, is observed in the descendants of those who, though not tubercular, are weakened by scrofula, cachectic diabetes, alcoholism, or simply by bad hygienic conditions; besides these causes the innate form may also be due to consanguineous marriages." Now when we shall have added this category of cases to that of the hereditary form, we fear the margin left to curability will be so narrow and shadowy as almost to escape gratifying observance. The author very frankly tells us that we are not to look for great success in this form. "Thus," he writes, "in the innate form there is a possibility, a *chance*, which removes from it the character of absolute incurability, which we were *bound to admit* in hereditary phthisis, when this diathesis was once realised." (The italics are ours.)

Now, as to two, at least, of Jaccoud's factors of innate phthisis,—"*alcoholism*" and "*consanguineous marriages*"—we are very much inclined to doubt their specific efficiency, when they are not allied to hereditary predisposition. Alcoholism,



no doubt, is occasionally the precursor of phthisis, but it is well known that the desire for alcoholic drinks is often the result, not the cause, of the organic evil; besides, the great majority of drunkards die of other diseases; and as to "consanguineous marriages," if the two parties to the contract are of well-established physical soundness their offspring will have a very fair chance of escaping, not alone pulmonary phthisis, but also any other hereditary ailment.

Jaccoud's third variety of phthisis are those, he informs us, "in which the pulmonary tuberculosis, being spontaneous and independent of other diseases, could only be due to general debility, to that insufficient or improper nutrition which is the basis of all forms of phthisis." He calls these cases the first group. He constitutes a second group in which he places "those cases in which the pulmonary disease is connected with a constitutional affection, either past or present, and to the existence of which it may be rationally imputed."

As regards the spontaneity and independence of Jaccoud's "acquired phthisis," we had better defer criticism until more is known of the bacillus of Koch. Still, it would be a pity to bereave the eminent French clinician of any part of the small residue of that field of "curability" to which his endeavour has reduced his right of possession. His book well deserves attentive study, for it contains much that must be found of real practical value. Had it come from the pen of a less able and eminent author we might have bestowed less notice on it. Youthful practitioners are but too prone to indulge in over sanguine expectations, when they light upon any work bearing the prestige of high authority; and when they realize a succession of practical disappointments, a spirit of medicinal skepticism is likely to be engendered, which may ultimately prove pernicious to themselves and harmful to their patients. Do not give up the ship, but see to your ballast, and do not indulge in studding sails and sky-rakes, in a perilous sea. Be warned by the wrecks of other navigators, rather than learn the dangerous sea line by your own calamitous temerity.

WASTING DISEASES OF INFANCY AND CHILDHOOD, by Eustace Smith, M.D., London. Wood's Library, April, 1885.

This work will be read with pleasure and profit

by every earnest practitioner of medicine. When we consider how large a proportion of all medical practice is presented in the diseases of childhood, we cannot but welcome any valuable contribution to so important a subject. The present issue is a reproduction of the 4th English edition. If we should single out any particular chapter of the book as of paramount value, it would be that one in which the author treats of "inherited syphilis," with which we find but one fault,—its brevity. But it is a *multum in parvo*. General practitioners in this country, but especially those residing in rural districts, may but seldom be confronted by inherited syphilis. This cannot be any reason for their avoidance of its study; rather indeed the very contrary, for exceptional cases are to be met with in all communities, and those to whom they are more familiar well know how puzzling they are, and how eminently important is their clear diagnosis. The practitioner must not deceive himself by expecting frank, much less, spontaneous, information from parents. In nine instances out of ten the soft impeachment will be repudiated, and not seldom disastrously resented—disastrously alike to the doctor and his innocent patient.

THE LAND OF ROBERT BURNS, AND OTHER PEN AND INK PORTRAITS. By J. Campbell, M.D., L.R.C.P., Edin., Seaforth, Ont. Sun Printing Office, Seaforth. Price, 75 cents.

We are glad to welcome this interesting work by our talented friend Dr. Campbell, of Seaforth, which we have perused with much satisfaction. We would especially note the chapter on the defence of Burns, the article on Sir Walter Scott, and also the reference to Knox and the Covenanters. The work consists in a series of letters written to the Seaforth *Sun* during a holiday trip to Scotland, a few years ago. These are now collected in the volume before us, to which has been added the valedictory address, delivered by the author on his graduation in McGill College, in 1869. The work is both pleasing and instructive, and cannot fail to interest a large number of readers. We congratulate our worthy confrère upon his success in the literary arena, and trust that the work will meet with a large sale.

ON MALIGNANT ENDOCARDITIS.—The Gulstonian Lectures delivered at the Royal College of Physicians, London, by Wm. Osler, M.D., M.R.C.P., Prof. Clin. Medicine, University of Pennsylvania. Reprinted from the *Medical Notes*. Philadelphia: Lea Bros. & Co.

A **HAND-BOOK OF PATHOLOGICAL ANATOMY AND HISTOLOGY**, by Francis Delafield, M.D., and T. Mitchell Prudden, M.D., of New York. Second edition. New York: Wm. Wood & Co.

The scope of the work in the present edition has been much extended and will be found to supply all the needs of the student or practitioner. It comprises instruction in the methods of making post mortem examinations, preparing tissues for microscopical examination, examining bacteria, etc. It contains a description of tumors, and also lesions in different parts of the body the result of disease, violence, or poisoning, and the like. The text is well illustrated, and the work on the whole one to be highly commended, and a valuable addition to the literature of the subject.

**THE PRINCIPLES AND PRACTICE OF GYNÆCOLOGY**, by Thos. Addis Emmet, M.D., LL.D., Surgeon to the Woman's Hospital, New York. Third edition. Philadelphia: H. C. Lea's Son & Co. Toronto: Williamson & Co.

The edition of this most excellent work now before us has been thoroughly revised by the author, and is illustrated by one hundred and fifty illustrations. The work is essentially a clinical digest, and includes the results of the author's experience. It also aims to represent the present state of gynæcological science and art. The author does not favor intra-uterine medication, and regards the different forms of pelvic inflammation outside of the uterus as constituting the chief factor in the diseases of women. The book is a welcome addition to the literature on this interesting and important branch of medicine.

**AMPUTATIONS OF THE EXTREMITIES AND THEIR COMPLICATIONS**, by B. A. Watson, A.M., M.D., Surgeon to the Jersey City Hospital. Illustrated by 200 engravings. Philadelphia: P. Blakiston, Son & Co. Toronto: Hart & Co.

The author of this new work is a thorough disciple of Lister, to whom the book is dedicated. The scope of the work is much broader than might be inferred from the title, inasmuch as the author deals with all possible complications of amputation wounds. A number of original wood-cuts have been introduced, but the majority are selected from the standard works on surgery, etc., both home and foreign. One important subject is treated of which is rarely found in surgical works, viz., the formation of desirable stumps for prothetic apparatus, the

point at which amputation ought to be made, and the selection and application of artificial limbs. We commend the work to the attention of our readers.

A **MANUAL OF THE PRACTICE OF SURGERY**, by Thos. Bryant, F.R.C.S. Eng., Surgeon and Lecturer on Surgery at Guy's Hospital, with 727 illustrations. Fourth edition. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

The two volumes of the English edition have been consolidated into one in the American reprint. This makes the work much more convenient for reference. As it has been recently revised by the author, it has been reprinted without any alteration. No words are needed from us in praise of the work, for both it and the author are favorably known to the profession in this country. The work fully and fairly represents the present status of British surgery, and as such we commend it to the attention of our readers.

A **TREATISE ON THE SCIENCE AND PRACTICE OF MIDWIFERY**, by W. S. Playfair, M.D., F.R.C.P., Prof. of Obstetrics in King's College, London. Fourth American from the fifth English edition, with notes and additions by R. P. Harris, M.D., with two plates and 200 illustrations. Philadelphia: Lea Bros. & Co. Toronto: Vannevar & Co.

This work is already well known to the profession as an excellent epitome of the science and practice of midwifery, and we gladly welcome the new edition. The work has undergone a careful revision at the hands of the author and his assistants, and the chapter on Conception and Generation has been re-written, so as to incorporate the most recent advances in Embryology. Several new illustrations have been added, and the work will be found a trustworthy guide in the anxieties and emergencies of obstetric practice.

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### Births, Marriages and Deaths.

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In Montreal on the 1st ult., Dr. P. E. Picault aged 76 years. Also Dr. Jos. Leman, aged 56 years.

In Kingston on the 19th ult., Tina Laura Stirling, beloved wife of Dr. K. N. Fenwick. aged 26 years.

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## Original Communications.

### DIPHTHERIA.\*

BY G. A. TYE, M.D., CHATHAM, ONT.

No subject can be presented to practical physicians that possesses a greater interest than diphtheria—a disease as ancient as history itself, and as widely spread as the human race. It stays not its ravages for country nor climate; it ruthlessly invades alike the hut of the peasant and the palace of the prince; it is not ashamed to claim its victims in the house of poverty, nor fears to enter the home of luxury. Many here to-day have had the circle of their own fireside broken, and every one here has felt his utter weakness when the home of his friends was desolated in spite of all his art, and to-day we unite our forces to meet a common foe.

We possess two means—*prevention* and *cure*—which enable us to lessen its ravages. Our greatest power at present lies in the former. It is a great satisfaction that at last we have a system of State medicine established in Ontario, and that legislative enactments now guard the birthright of every subject's health. Such legislation marks an advance in true civilization. The country owes much to the Ontario Board of Health for its energy, intelligence, and thoroughness in carrying out the Act. The people of Ontario are being rapidly educated in sanitary matters, and there are fair prospects that the prevalence of this disease, as well as many others, will be soon limited.

The report of the Registrar-General shows that it ranks high amongst the fatal diseases of this Province. For the year 1876 he reports a large increase in the number of deaths. In 1874 the deaths were not sufficiently numerous to be placed in the list of the ten highest causes of death, but in 1876 it stands third. Many deaths really due

to diphtheria are returned as croup: but the death rate from croup also increased in the same year, showing that they were probably due to one cause. In 1877 it stood fifth; 1878, fourth; 1879, sixth; 1880, fifth; 1881, fourth; 1882, fifth, in which year there were 1,239 deaths from this cause alone.

The predisposing causes are telluric, meteorological and individual. Amongst the former are low, damp situations. Houses are placed close to the ground, with no provision for currents of air to pass beneath them to dry the soil or expel noxious vapours. Houses too closely surrounded with plants, shrubbery, or trees, are favourable to the development of low organisms. River flats, sites of old saw mills where there is much decomposing sawdust, seem to be prejudicial. I have observed several cases apparently due to these causes—at least no other could be found. I have notes of nine cases observed in the autumn of 1884, which occurred within two weeks in two adjoining blocks of small tenement houses, placed close upon the flat, damp, undrained ground. Dr. Ryall, Medical Health Officer of Hamilton, reports to the Board of Health (in April last) of that city, the condition of the premises in which diphtheria was found. The description is so vivid and terse that I produce it: "The results of the examination of the affected districts revealed cellars dirty and damp, smelling strongly of sewer gas, vegetables stored in cellars decomposing and smelling badly, kitchen sinks and baths untrapped and unventilated, being connected either with sewer or water-closet, or bad smells in back yards, defective pan water-closets, soft-water cisterns under the kitchen floor, well-water used which received drainage from the surface manure heaps. A few cases occurred where the premises were in good order, but the surroundings were bad." The germ of diphtheria, whatever that may be, always finds in such conditions a suitable nidus for development—breeding spots where one germ generates many. All these causes are in the preventible list, and with the aid of the physician the people can remove them.

Meteorological conditions of a certain kind are strongly predisposing. The Michigan State Board of Health finds that diphtheria is increased by—increased daily temperature above the average for that period of the year, increase of humidity, increase of cloudiness, excess of winds, excess of ozone, high barometric pressure. Our own health

\*Read before Ont. Med. Association, London, June, 1885.

reports establish the fact that the disease is most prevalent in November and December, when many of these conditions exist. During this period there are high barometric pressure, magnetic displays, and an electrical condition of the air producing nascent oxygen and ozone. The experiments of B. W. Richardson show that these gases are irritating to the respiratory passages, hence we find an excess in sore throats, and a corresponding increase in diphtheria. We must conclude from these premises that sore throat is a favourable locality for the reception of the diphtheria germ. The throats of children are very susceptible to atmospheric changes, and consequently age is a predisposing cause. The greatest mortality occurs from two to five years of age. The Registrar-General's Report for 1879 states that, of 574 deaths, 283—or about one-half—were under five years; 184 between five and ten. In 1881, 72 per cent. were under sixteen; in 1882 there were 1,239 deaths, 83 per cent. were under fifteen. The *exciting* cause of this disease is probably a germ from some former case. Bacterial pathology has not yet clearly established its nature. The natural history of these germs teaches us that they thrive best where there is moisture and decomposition of organic matter, and continue to produce their kind so long as favorable soil is present, and that those already formed may linger long in a locality after the production has ceased.

Dr. Bryce in the Health Report for Ontario, says there does not appear in the whole catalogue of disease one which is so persistently endemic in a locality when once introduced. What are the modes of communication? It is communicated by the direct passage of morbid material from a diseased throat to one previously healthy. The history of tracheotomy presents some lamentable illustrations of this fact. It may be communicated by the inhalation of germs existing in an insanitary locality, although no case of the disease then exists there. It is communicated by germs wafted in the air, and that for a considerable distance; and they produce the disease, more especially when a predisposition exists, so that many suffer whose sanitary surroundings are apparently perfect. The clean, as well as the unclean, may be obliged to share the calamity. I shall confirm these propositions by a few cases. A medical man reports to the Provincial Board that the mother of a large

family laid out the body of a little girl dead of diphtheria. In a few days four of her children were down with it. The pall-bearers were boys. One of them took it home, and seven of that family were taken ill.

Last December I saw a boy, aged fourteen, then ill for five days. His mother saw membrane in the throat. Croupy symptoms were strongly marked. It was a serious case. I found that three weeks previously he passed the night at the house of an uncle, and slept in a bed in which a child had recently died of diphtheria. Dr. Holmes, of Chatham, related a case which seems to show that it may be carried in clothing. A gentleman called at a house on business, and was obliged to remain there some hours. The disease existed in this house. He went to his own home some miles distant. No cases were near his own residence, yet both wife and child took the disease, and the child died.

Dr. Mullin, of Hamilton, tells of a family under his care; four members suffered; the first a school-boy; the early indications appeared Nov. 6; the other children were sent from home at once, and the patient was convalescent on the 13th. The other children were brought home on the 20th, and efforts made to keep the convalescent one isolated; however, on the 30th another was seized; Dec. 1st another, and on the 6th the third. He says the occurrence in the last three seems to him fairly attributable to contagion from the first.

During the winter of 1884, I observed a number of cases in one neighbourhood, which seemed to prove its passage in the air. In a tenement house, standing alone in a filthy state, two children died of diphtheria; across the street, and a few rods eastward, was a row of houses, all situated on high, dry ground, fair water and families in good circumstances. In a few weeks after the deaths in the tenement house, it appeared in this row, which was in the direct course of prevalent winds; two children in one house, five in the next, and four cases in the third house, in all 11 cases occurred in this row of houses; the two in the first house recovered; one of the five in the second house died of heart paralysis some days after apparent convalescence, another had a narrow escape; in the third house one died; a visitor had contracted tonsillitis while boating on a damp evening; she died from stenosis of the larynx. Four weeks later five cases oc-

curred in an adjoining block, in my care ; another case close by attended by another physician ; some weeks later, in a house close to the original outbreak, but on an opposite side, two children died in one family, altogether 19 cases and 6 deaths in a radius of about 20 rods. Our Board of Health was not yet organized ; had there been means to have thoroughly cleansed house No 1, I believe disease and death would have been prevented.

Prophylaxis is a most essential part of the treatment, for more can be saved by prevention than by cure. It must be confessed that our treatment is not yet what we may hope for. The prophylactic measures can be inferred from the etiology already stated. Let the unaffected ones of a family be isolated at once, if possible, in another house, and in a different locality, as high and dry as can be secured, and let the quarantine be prolonged. All exposure to cold winds must be avoided. Keep throats of sound children disinfected with proper applications. I am sure this will prevent some cases. Every case of sore throat should be promptly treated. Rooms occupied should be large, well ventilated, and kept at an even temperature. The vapour of turpentine, tar, or sulphurous acid are probably useful, and are very well tolerated. Every infected locality should be visited by the authorities and completely disinfected to prevent the spread of the disease.

The question of the identity of croup and diphtheria has been discussed for some time without reaching a definite conclusion. The views of Lewis Smith in a recent article are correct, that membranous croup is not a disease of itself, but an outcome of other diseases or conditions, and states them in the order of frequency : 1. diphtheria ; 2. cold ; 3. measles ; 4. pertussis ; 5. scarlatina ; 6. typhoid ; 7. irritating inhalations. He says that in all instances the morbid anatomy, clinical history and required treatment of the croupy state are nearly identical ; and that attempts to differentiate them are futile. This puts the identity as regards treatment too strong, for in diphtheritic croup the system's condition is more adynamic than in croup from cold. In croup from other causes there is a sthenic condition, stenosis is the principal difficulty, and calomel can be pushed farther or jaborandi used.

Jaborandi was tried extensively in the terrible epidemic of diphtheria in Russia a few years ago

in the croup cases, upon the theory that the abundant secretion produced would so influence the condition of the parts as to prevent the formation of membrane or dislodge that already formed. The statistics do not favour its use in diphtheritic croup from its depressing tendencies. In cases of croup due to cold I have found it a powerful agent for good, and children tolerate this drug to a remarkable degree.

The *treatment* of this disease has a superlative interest. It is strange how many specifics there are—how many there are that find sure cures and safe cures. There are medical men who say they have never lost a case. Happy is the man who can so flatter himself. The local treatment is secondary in importance to the general treatment. The throat is now no longer injured by caustics, acids and rough swabs, which would produce a sore throat where none already existed. The throat should be kept as clean as possible with frequent gargles of hot water, which lessens the hyperæmia. Solutions of chlorate of potash are grateful. A soft camel's hair brush should always be used to make applications. There are many applications so equally good that it makes little difference which we employ. Sulphurous acid and glycerine, with the addition of thymol, is effectual and pleasant. Oil of eucalyptus and liquid petroleum make another good topical remedy. Lactic or acetic acid with glycerine I have found useful. The atomizer is an excellent instrument to make applications to the throat by the mouth, or through the nose, where the patient's age permits. Much harm can be done by using violence to dress the throat. Solutions that permit of being swallowed are better than forcible swabbings. Formerly membranes were eagerly detached, leaving a raw, bloody surface, upon which a new membrane rapidly forms, often in 24 hours. The membranes should be well cleansed and disinfected, and allowed to drop off when ripe for separation, after which they rarely return. Loose, hanging portions can be removed with scissors. Rossback, of Germany, after four years' trial, speaks favorably of the vegetable digestive papayotin. It acts well in an acid or an alkaline medicine. Dr. Lewis Smith mixes one drachm of Fairchild's extractum pancreatis with three of sod. bicarb, then adds one teaspoonful of this to six of water and pencils the fauces, and uses trypsin with the atomizer for mem-

branes in the larynx. A discussion of this subject at the last meeting of the American Medical Association confirmed the use of tried remedies, but nothing new of value was introduced.

The longer I treat diphtheria the more am I convinced of the power of tincture of iron, alcohol, quinine, and chlorate of potash, but the first mentioned is superior to all. These articles are all eminently safe, whether the tendency to death be from asthenia or from asphyxia; but the best effects of iron are seen only when administered in very large doses. Dr. Jacobi, in the *American System of Medicine*, recommends from 5 to 15 minims properly diluted every fifteen minutes or half hour, and I am sure from my own experience that this is valuable teaching. There is certainly a tolerance of the drug in this disease.

Alcohol given early and freely stands next to iron. Austin Flint, in an admirable article on Medicinal and non-Medicinal Therapeutics, thus speaks of alcohol in this and kindred affections: If alcohol be useful as a material for combustion within the body, it is indicated in the condition of fever, prior to the indication for its employment to sustain the failing powers of life. The object from this point of view is to forestall these indications and prevent the asthenia. It is evident that employed with a view to test fairly its value as an antiseptic or parasiticide, or as an antidote, it is important that it should be employed early, continuously, and in as large quantities as it may be tolerated.

Chlorate of potash is a well established remedy, but given in very large quantities will produce nephritis and albuminuria. Quinine in tonic doses is an excellent adjunct, but its bitter taste makes it difficult to administer to young children. When croupy symptoms appear there is still a possibility of arresting the further progress of the membrane by the increased dose of iron and alcohol. For many years I have found excellent results from the frequent administration of small doses of calomel, one gr. per hour, and free inunction of the neck with oleate of mercury. I know no remedy equally potent. The inhalation of moisture, in the form of vapour, is beyond doubt of considerable value. The atomizer is the best instrument for producing the vapour. I have tried to use ice, but my patients would never tolerate it long enough to judge of its merits.

When the stenosis continues to increase in spite of remedies, no time must be lost if the trachea is to be opened; for if there be any hope from the operation it is when done comparatively early. The results are not encouraging. The benefit of this operation, so manifest in croup from other causes, is not found in diphtheria, for it does not check the disease. Dr. Holmes, of Chatham, informs me that he has operated three times with a fatal issue in every case, but he would advocate the operation for euthanasia.

The albumen of this disease is rarely due to a nephritis, but to congestion of the kidneys, for it rarely produces dropsy or uræmia, and recovery is rapid after the cessation of the cause. The dyspnoea produces general engorgement which the kidneys must share; or the vagus being effected, the heart is weakened, and the congestion is due to this cause. The paralysis of diphtheria is fortunately not very frequent; some epidemics are much more marked than others by its appearance, and unless it involves the heart, or the paralysis is general, there is a strong tendency to spontaneous recovery. I have used faradism, but cannot say that it has hastened recovery. There is some evidence that galvanism has a beneficial influence. Professor Thacher, of Yale, has made some careful observations on the effects of massage, faradism and galvanism. There was a positive gain from galvanism, no effect from faradism, while massage seemed to lessen the power.

#### PLASTER SPLINTS IN THE TREATMENT OF FRACTURES.\*

BY N. A. POWELL, M.D., EDGAR, ONT.

MR. PRESIDENT,—When, a year ago, I proposed that instead of the annual reports containing digests of the progress in each department of medical science, such as had been presented to you, discussion should be arranged for, I did so with the conviction that the existing facilities for the rapid transmission of medical events to every reading member of the profession render such reports no longer necessary. In offering a resolution which you saw fit to adopt, I had no thought that like Haman of old I should be the first to appear on the gallows which I had moved to erect for another.

\*Read before the Ontario Med. Association, June, 1885.

However, being here, in hope that the interest attached to the subject may redeem my faulty presentation of it, I ask your attention to the use of plaster splints and bandages in the treatment of fracture. Of all the materials which may be used to form dressings, soft when applied but rapidly becoming hard and unyielding, this is the best and the best is just good enough till we can improve upon it. Plaster of Paris or gypsum, used in surgical practice by the Arabs in the last century is perhaps not better than when first introduced, but the methods of its use have undergone a process of evolution and are now so perfect as to merit the close attention of each one of us. A clear distinction must be made between such splints, and bandages. By the first we mean supports moulded to a part only of the circumference of a limb or other portion of the body, while by the last we mean dressings which completely encircle the extremity requiring fixation. The two forms of course may approach each other till they meet and merge. As a class the splints are removable at will while the bandages are not so. This distinction is important since the risks belong almost entirely to the bandages, while the benefits can as a rule be obtained by one form or another of plastic splints. Believing that in regard to comfort and security from displacement they are, in the treatment of certain selected fractures better than any other means at our command, I have raised the question of their use in the hope that through you, and with your aid, it may be possible to reach and impress a number of our brethren who either do not use these appliances at all, or do not use them in ways most convenient for themselves and most helpful to their patients. It is to be expected that the discussion evoked will be of greater value than the paper read, since it will become the means of recording a wider experience and reflecting the ideas of others from different standpoints. Let me remind you that your indication of points upon which we differ may be productive of more good than a silent reception of whatever is advanced. With the object of economizing time I shall spare you historical details, shall speak perhaps somewhat dogmatically, and shall give you conclusions rather than the reasons which have led me to them. I shall seek less for originality than for practical utility, and whether speaking or listening shall not forget the saying of Paget, that each one of us has some-

thing which he may teach, and much more which he may learn. If upon some points I enter into detail, it will be because of a belief that in attention to these minor matters lies all the difference between danger and safety, between success and failure. I base what I have to say on what I learned as a student from my old and honored teacher Dr. F. H. Hamilton, of N.Y., on ten years constant use of gypsum dressings, on such study as I have been able to give to the literature of the subject, and on what I have from time to time seen in the hospitals of New York, Boston, and Philadelphia. I trust that some who hear me and who have had trans-Atlantic experience will give us the results of their more extended observation.

*Materials*—Only the finest and freshest dental plaster should be used. The common sort applied as a hard-finishing by plasterers is not fit for surgical purposes and its use invites failure. The office supply should be kept in tins the covers of which screw down air tight upon rubber rings. Cosmoline tins, of five lbs. size, may be obtained at any drug store and answer the purpose perfectly. In preparing the mixture of plaster and water known as "cream" the solid should be added to the fluid and not the fluid to the solid. About an equal bulk of each makes the proper proportion. Common salt or the sulphates of soda or potassium or alum can be added to the water to hasten the setting of the plaster, while a weak solution of glue or gelatine, if used, would delay such crystallization. Cloth sufficiently porous to allow the plaster to set in its meshes and not simply on its surface is the other essential. The experiments of Drs. Marcy and Nelson proved that the lightest and strongest of plaster dressings were those made from cotton cloth such as is used for printing upon. This, free from fatty matters or starch finish is only to be obtained from the bleacheries. It differs from cheese cloth as cotton batting differs from absorbent cotton. Cylinders made with it and plaster, crushed down only at a pressure of 110 lbs. while those of equal weight and thickness made from crinoline crushed at 60 lbs., and from cheese cloth at 10 lbs. Acting on this hint I have been in the habit of using cheese cloth for plaster bandages, first preparing it by boiling in an alkaline solution and then in clear water to remove the alkali. I am satisfied that the gain in strength is sufficient to pay for the trouble, but regret that I cannot as yet



make a more accurate statement. The size to be preferred is a width of three inches and a length of three yards. Into the meshes of such bandage material the plaster is to be rubbed by hand, and then each roller is to be wrapped in paper if it is not to be used at once. They can be best kept in the tins covered by a layer of plaster. From un-sized cheese cloth, from bleached Canton flannel, from cheap, that is cotton-containing flannel, or from old blanket, all other plaster dressings may be made. As a protection for osseous prominences and as a lining generally for plastic dressings, unbroken rolls of the finest cotton batting, white cotton wadding in roller form or blanket flannel will be required. A solution of the bicarbonate of soda in water or the white of an egg will remove the unpleasant feeling left in the hands after using plaster.

*Methods*—Upon the principles of the treatment of fractures there is general agreement, but on no subject in surgery do opinions differ more widely than upon the methods by which these should be carried out. In part this is due to the fact that similar good results may be obtained by so great a variety of means. The particular plan employed is of much less importance than the skill and judgment used in its application. A surgeon with strips of wood, padded with moss, and secured by thongs of basswood bark, will succeed, where a mal-adroit backed by a brigade of surgical machinists will fail. Progress of late has been in the direction of simplicity with efficiency, and these are marked characteristics of plaster dressings. The material affords scope for the ingenuity and dexterity of the ablest of surgeons, while on the other hand it may be used in safe and simple ways by any one who will take the trouble to master the *technique* of such dressings. Not to every one is given the ability to invent modifications, as special cases require them, but good methods and correct models are not hard to follow. The plans we shall consider are not the results of any one man's work. Many have labored and we enter into their labors, since that which is of value the profession retains and develops. We may justly claim that

"All of good the past hath had  
Remains to make our own time glad."

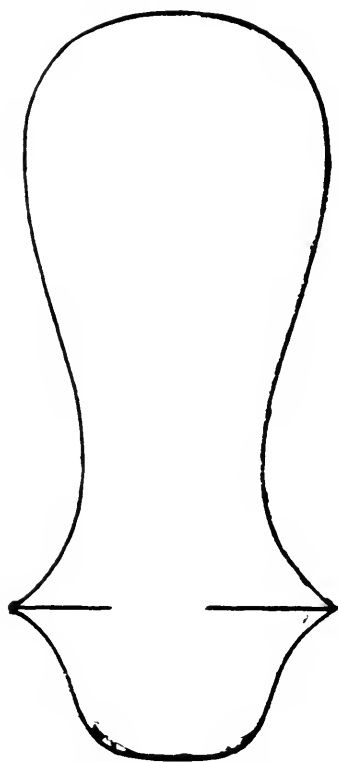
The spiral bandage with plaster in its meshes applied over a leg fracture may be taken as a type of all the uses of the roller. I shall describe some-

what minutely what I hold to be the best manner of its application. The limb, if hairy, is to be oiled, and then it is to be enveloped in a thick layer of cotton batting taken unbroken from a roll. This layer should extend from the toes to the mid-thigh, should meet in the middle line in front and should be held in position by thread wound around the leg. Over this is to be applied with moderate firmness by the figure of 8 turn, and without reverses, a dry cotton roller. This must not be confounded with that relic of the dark ages a "primary bandage." The gauze cloth or crinoline bandages before described are to be next placed two at a time on end in a bowl of warm water. When the bubbles cease to escape they are taken out pressed to expel surplus water, and are applied from the toes up. No one turn should be drawn more snugly than another. If too tight there is danger of strangulation, while if too loose the risk is that co-aptation of the fragments will not be maintained. Each layer as applied should be well rubbed by the hand to expel the air between it and the one next beneath it. From three to six layers will be required. An assistant is to make moderate extension during the application, and for from ten to thirty minutes afterwards. The heel should rest in his right palm, while his left hand is passed around the instep. If seated comfortably, and able to rest his forearm against his knees he will be able to hold the foot at right angles with the limb, prevent rotary displacement by sighting over the great toe and inner margin of the patella and will not become unsteady through muscular fatigue. To bring the toes up after the dressing is completed is dangerous, since it is apt to constrict at the instep. To allow them to drop is to run the risk of having the heel permanently elevated. When the limb is a heavy one, an inch wide stiffener of perforated tin may with advantage be interwoven in the bandage at each side. When the shell has become fairly firm the limb is to be placed upon a moulded pillow on which in from two to four hours it will become sufficiently rigid to stand being suspended. Such an apparel, light, shapely and perfectly fulfilling the indications, is the one I ordinarily employ in the *later* stages of leg fractures. It gives a firmer support than any hinged splint, and its use will materially shorten the period of confinement to bed. An elevated shoe on the sound side will assist the patient to keep the promise exacted from him that

he will not, till allowed, bear weight on the injured limb while moving about on crutches.

In recent fracture I much prefer an apparel that will allow examination from day to day till the consolidation is well advanced. Even after the most perfect reduction I want to *know* and not simply to *hope* that the fragments maintain their proper position, and that the soft parts over them are in good condition. In 1872 I first applied what is known as the Bavarian or book splint. After using it a few times I began to substitute shaped pieces of cheese-cloth saturated in plaster cream and placed between the inner and outer flannels, for the thick usual layer of solid plaster. With this hinged splint I have treated about thirty fractures of the bones of the leg. It is lighter and stronger than the Bavarian, as ordinarily made, and it can be applied with safety when to use a plaster bandage would be malpractice. By placing the limb first on one side and then on the other the halves of the splint can be raised like lids, and the seat of injury examined without risking in the least a disturbance of the process of repair. I show you one of these, but shall not urge its claims upon you since I wish to use the time at my disposal in advocating a still better and more easily applied retentive apparatus. This is one that I first saw at the Boston City Hospital three years ago. It is known as the "plaster posterior splint," and its development is largely due to the skill and ingenuity of Dr. R. A. Kingman, of Boston. This gentleman writes me that the original idea came from Brooklyn, N.Y., and that his connection with it has been in improving its details and demonstrating its utility and practicability. Through his courtesy I am able to show you three photographs of one of these as applied before the Massachusetts Medical Society last year, after the reading of a paper on the subject by Dr. Geo. W. Gay, surgeon to the City Hospital. I show you also a completed splint and a pattern of the shape into which the material for it was cut. One surgeon, well able to judge, considers this to be the most important advance in the treatment of leg fractures within the last fifty years. Another, and with him I certainly agree, thinks that it comes nearer than any other to being an ideal dressing for a broken leg. Unlike the Bavarian it is always open, permitting sufficient examination without disturbing the limb. It is also far easier to apply, and when applied is self-retaining. It

may be made in this way: The limb is first bandaged with wadding in roller form, enough being used to protect the bony processes and the tendo-achilles from pressure. A single layer of gauze or crinoline large enough to extend from the toes to above the knee, is to be placed beneath the limb closely wrapped about it and cut so as to completely surround it with the exception of a space about an inch wide on the anterior aspect. This piece serves as a pattern by which the other layers, six or eight in all, are cut. The cloth is to be deeply slashed on each side opposite the point of the heel to allow the foot piece to be brought to



Pattern of "Plaster Posterior Splint."

a right angle without forming clumsy folds. The layers are now to be soaked in plaster cream, placed one upon another, applied to the limb at once and moulded closely and carefully to it. At the sides of the ankle where the angles from the foot piece and the leg piece overlap, I find it gives the neatest result if they are interlocked two at a time. A bandage rapidly applied secures a perfect fit of the splint to the limb and can be removed when the plaster has become firmly set. If no bandage be left on the leg the splint will accommodate itself to

any reasonable amount of swelling. Some cases of Pott's fracture with marked eversion of the foot require more powerful pressure to maintain reduction than this appliance can give. For the cases however to the treatment of which it is adapted it will be found a comfortable and efficient, as well as a light, safe and æsthetic dressing. While I would hesitate to advise the adoption of the spiral bandage as a routine dressing for recent fractures, I feel free to say that its advantages can be secured and its risks avoided by the use of the splint just described. Swelling may not, and in the vast majority of cases will not occur if this be early applied. Such swelling is no more a necessary accompaniment of the repair of a fracture than of the healing of a strictly aseptic wound.

*For what fractures is the treatment by gypsum to be recommended?*—For those of the lower jaw, in which an inter-dental splint either is not required or is not obtainable. Six layers of cheese-cloth (or two of Canton flannel) cut to the proper size and shape, soaked in plaster cream, moulded to the part, coated when hard with spirit varnish to afford protection from saliva and lined with cotton or Canton flannel, will make an appliance as serviceable as any other. A Barton's bandage will retain it in position. I show you one made in this way. A broken clavicle can be treated in half a score of ways, any one of which would fulfil the indications as well as any application of plaster of Paris with which I am acquainted. The humerus broken in any part may be safely and securely retained with its fragments in normal position by shoulder caps, internal angular splints or some combination of these made rigid by plaster. The internal angular splint is also, in my opinion, the best for fractures at or near the elbow. I show you outlines of the shapes into which cloth may be cut to form these supports, and also have here completed splints. The angular ones have no special advantage over those of similar shape which may be made from softened binders-board. No single fracture of the forearm is as well treated by plaster as by properly padded wooden splints. A plaster bandage seems to me to be the worst of all dressings for those which occur near the carpal end of the radius. It tends to press the bones together and to obliterate or narrow the intervening space. It prevents the frequent examinations so requisite here. It constricts a part which being dependant

is apt to swell and it has not even the excuse of adding to the patient's comfort. Just here let me protest against the dangerous doctrine that all may be considered to be progressing favorably if only the fracture gives no pain. The worst results I have ever seen have come from an acceptance of it by those who are using plaster in an unskilled manner. The problem presented by a Colles' fracture is best solved by, first, a perfect reduction and, second, the accurate pressure of a dorsal pad over the lower fragment and a palmar pad over the lower end of the upper one. Such correctly limited pressure is what we cannot get with a plaster bandage, and so I condemn its use here. Under exceptional circumstances a plaster jacket might be advisable over broken ribs, but unilateral strapping with imbricated strips of good moleskin plaster has sufficed in all the cases which I have so far seen. A recent fracture of a thigh bone may be put up by experts in a hospital, where from hour to hour it will be under observation, but under other circumstances this method is not to be commended. The dangers are greater and the results are not proven to be better than by the alternative plans. Drs. St. John, Marcy, Cowling, and Sayre, have urged the adoption of the plaster bandage as a routine dressing for these lesions, but the vast majority of those who, like myself, have fairly and without prejudice tested the plan, have given it up in favor of the two others which have a right to our entire confidence. These are Buck's modification of the weight and pulley extension of Hildamers, and the Smith-Hodgens' oblique suspension. A surgeon at the present day who has had shortening or deformity after a thigh fracture to account for to a jury, will be less likely to be mulcted in damages if he can prove that with intelligent and conscientious care he has used one of the above plans, than if he has put his trust and his patient's limb in plaster, or as Rip Van Winkle might, has depended on the long splint of Lister.

My conviction is that continuous and equable extension, indispensable here, is not maintained by the most perfectly applied plaster bandage, still less by any plaster splint. After fairly firm consolidation I do not object to this form of support, although by it I have seen a knee so stiffened that its patella was fractured in the attempt to regain motion by *Brisement forcé*.

Taking up next the patella I shall only state my

entire approval of the splint made according to the method of the late Dr. J. L. Little, of New York. The oblique strips to fix the patellar fragments, hardening while the fingers of the surgeon hold the parts in apposition, are better than adhesive plaster or anything else of which I have knowledge. Dr. Little's paper can be found in the *Medical News*, March 29th, 1884. With few exceptions fractures occurring below the knee are better treated by plaster than in any other way whatever! A fracture box, filled with oakum, may be used for a few days if swelling is extensive. If not, a hinged or posterior splint, as described, should be applied, and the limb at once suspended. Any blacksmith can make, for a few dollars, a Salter's cradle, which put together with thumb-nuts is very portable. In mine the limb is supported on strips of bandage, exactly as in Hodgen's thigh splint. The saddle pad required to prevent very oblique fractures of the tibia from becoming compound, or used for the same purpose in connection with the V or Y shaped fractures of the tibia, so well described by Gossulur, can be well applied if a posterior splint has been reinforced by three strips of tin in its substance. Time does not obtain for my discussing at any length the subject of compound fractures, yet it is just in this class that plaster dressings have given the most brilliant results. Fenestrated or bracketed plaster bandages, and antiseptic occlusive or "through drainage" methods have changed the prognosis in these injuries, lessening the number of cases that demand amputation, and reducing to a minimum the septic dangers that are to be feared in an attempt to save the limb.

*What risks attend their use?* These depend on the selection of unsuitable cases, an improper application of the dressings, or an improper management after application. No solidifying dressing should ever be applied to a recently broken limb if much contusion, swelling or ecchymosis exists, or if there is doubt as to the integrity of the deep vessels of the limb. The toes or fingers should always be left uncovered, and should be watched so that on the least evidence of sluggish circulation the encasing material may be cut down or otherwise loosened. Circular compression and strangulation are most to be dreaded. A plaster case may look well and yet be the cause of deadly danger. It cannot be denied that the bad results following the plan of treatment we are discussing are

out of all proportion to the number of cases treated by it. Too frequently the usefulness of the limb and the reputation of the surgeon have been involved in a common ruin. Its intemperate and indiscriminating advocacy by certain men who ride their hobbies with whip and spur, have led to its employment by those not practically familiar with it, and too indolent or careless to become so. Dr. Coskery, for instance, at the last meeting of the Med. and Chir. Soc. of Maryland, stated that "it was highly improper to keep a patient suffering from a simple fracture of the thigh, on his back even for 48 hours. Such treatment would be a justifiable cause for a suit for malpractice. Dr. Sayre in a private letter read at the meeting of the Georgia State Medical Society in '84, said, "I dress *all* fractures simple, compound, comminuted and complicated, immediately after the accident if I can see them before the swelling has occurred . . . and a perfect recovery without deformity is the rule instead of the exception as was formerly the case." Dr. Sayre's statistics, as most of us know, are being constantly, though perhaps unconsciously, moulded to fit his theories. Like a good microscopist, he *can* see anything that he *wants* to see, but it is only just to him to say that he really *does* see more that is commonly overlooked than any other surgeon with whom I have the honor of an acquaintance.

#### *Advantages claimed :*

1. The fit being perfect there is little liability to displacement.
2. Support sufficiently firm to prevent displacement is obtained before even the busiest practitioner has to leave his patient. This is not the case with any similar plastic material.
3. Compression is uniform, limiting extravasation and controlling muscular movements.
4. In some form these dressings can almost always be applied at the first visit.
5. The material is always at hand and costs almost nothing.
6. Apparatus made from it can be depended upon not to contract in drying, as those made from other plaster materials do.
7. They are sufficiently porous to permit the escape of the perspiration.

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DR. OLIVER WENDELL HOLMES says that a doctor's patients must put their tongues out, and a doctor's wife must keep her tongue in.

## RENAL CALCULI.\*

BY A. GROVES, M.D., FERGUS, ONT.

In the comparatively brief time allotted to readers of papers before this Association, I propose to discuss the subject of renal calculus, first as to its causes and then briefly indicate the line of treatment I have found most beneficial in my own practice. In order to show that the subject is one of great importance and well worthy the serious consideration of all members of the medical profession, it is only necessary to recollect that forty-seven per cent. of all infants whose kidneys have been examined were found, according to Ebstein, to present evidences of uric acid infarctions, and it is also a well known fact that more than ninety per cent. of all cases of stone in the bladder have originated in a small concretion that had passed down from the kidney.

Several theories have been advanced to account for the formation of renal calculi, such as the catarrhal, the gouty, the diathetic, etc. By those who believe in the purely diathetic origin of calculi it has been argued that there are three diatheses, viz.: the urate, the oxalate and the phosphatic, one of which was the cause of renal stone in any given case. My own opinion is that with some rare exceptions the formation of primary kidney stone depends upon a predisposing cause which may be called the uric acid diathesis, and certain exciting causes incident to the food and surroundings of the individual, together with a precipitating cause without which stone is not deposited. The exciting causes determine the particular variety of calculus which may be found in any given case, but in the absence of the other two factors the exciting causes will not result in calculous deposit.

The mere presence of the diathesis alone will not cause the deposit of stone, for many persons habitually pass large quantities of uric acid without the development of any form of calculus. Ultzman has demonstrated that when the urine is only mildly acid, uric acid is deposited in normal rhombic prisms, but that if the acidity be increased the crystals take the form of elongated, pointed and radiating rods, and that it is precisely these spiny crystals that are found in cases of calculous pyelitis. Dr. Ord shows experimentally that the

form in which uric acid is deposited is often determined by the other urinary constituents. Eichorst cites a case where a gentleman invariably passed several uric acid concretions after drinking moderately of wine, and I have had under my care for some time a patient who is regularly attacked with renal colic during pregnancy, but at no other time.

Persons who are exposed to the same influences and who are similarly nourished, always have the same character of kidney infarction. Thus in the foetus and young infants, whose nourishment and surroundings are measurably the same, none but uric acid infarctions are found, but the conditions as to food and surroundings being changed other forms of deposit take place.

It would appear that dyspepsia has a considerable effect in determining the occurrence of calculous disease, hence those of sedentary habits are oftenest affected. A purely vegetable diet also seems to tend to the production of stone, and it is admitted by almost all authors that malt liquors have the same effect. Although not proven it is highly probable that diet has a considerable influence in the production of calculi. Cheshire, England, is almost exempt and the people live largely on a mixed diet, into which milk enters in no small amount, whilst Norfolk, with a population of between 400,000 and 500,000 has annually as many cases of calculous disease as the whole of Ireland, where milk also enters largely into the food of the people. Mr. Cadge believes that the great prevalence of stone in Norfolk is to be to a great extent accounted for by the inadequate supply of milk and to the universal prevalence of beer drinking. He is also of opinion that the effect of accumulated hereditary predisposition, in other words diathesis, is a factor entering largely into the causation of lithuria.

It is a doubtful question whether or not water containing lime salts favours the production of stone. My own limited experience would tend to support the opinion that water from limestone rocks has a tendency towards the production of renal stone. I have found that in the county of Wellington, along the Grand River, which runs through limestone rocks, calculous affections are comparatively common, so much so indeed that I rarely find myself without one or more patients suffering from calculous disease. I am at a loss to account for this prevalence of such disease on any other

\* Read before [the Ontario Medical Association, June 3rd, 1885.

hypothesis than that it is connected with the hardness of the water, for the food, clothing, habits of life, climate, etc., do not differ from the people around them. Dr. Roberts points out that a certain district, a suburb of Manchester, has furnished a considerably smaller number of cases of stone since the use of softer water supplied by water-works has taken the place of hard well water, and he gives no other explanation of the falling off in the number of cases.

Professor Gamgee draws attention to the fact that sheep pastured in limestone districts are particularly prone to become the victims of calculus, whilst under other conditions it is a rare affection amongst them.

In Finland, stone is an almost unknown disease, and the water coming mainly from granite mountains is remarkably pure. The Finlanders however are not addicted to excesses of any kind, live active lives and subsist on plain diet into which milk enters to a considerable extent. Estlander believes that the hot vapour baths common amongst them has a marked influence in securing that immunity which is so remarkable.

It would appear that the negro race are rarely affected with calculous disease, American statistics showing a proportion of not more than one to six of the white population. So far as my investigations have gone, I believe a similar immunity is enjoyed by the American Indian. It would appear that in these races the diathesis is less strongly marked, and that they are less exposed to those influences which tend to cause renal deposits, such as drinking strong or malt liquors, indigestion and sedentary habits.

There are renal stones which may be classed as purely accidental, such as those commonly occurring in Egypt, where the nucleus is found to consist of the ova of the *Diastoma hæmatobium*, also those instances in which blood clot, etc., forms the nucleus. In these cases the formation of stone is secondary, the nucleus being really a foreign body and consequently they ought to be classed separately from those arising idiopathically.

It is a rather remarkable rule, to which there are many exceptions, that only one kidney is affected by calculous deposit in the same patient. The explanation of this peculiarity which I would offer is, that inflammatory or catarrhal attacks probably affect only one kidney at one time as is usual in

other double organs such as the lungs, and that even a mild catarrhal attack produces a colloid material in persons predisposed to calculous disease. Rainey has shown by experiment that the presence of colloid matter causes the precipitation in spheroidal masses of crystalline salts, and this is the form in which uric acid nuclei are found. If only one kidney be attacked by the catarrhal inflammation or by congestion, that alone will be the seat of calculus; if both be attacked then stone formation may take place in both kidneys simultaneously. It might be objected to this theory that many victims of renal calculus have never had symptoms of catarrh of the kidney. My reply is that kidney catarrh usually presents no marked symptoms, and might very easily be overlooked, that in fact catarrh of the kidney is an exceedingly common occurrence. It may be caused by a glass or two of beer, by the chilling of the skin in a cold bath, even by purely mental causes as most people have had more or less demonstration of in their own persons. To epitomize, then, I believe that these three factors are necessary for the production of renal calculus. First a special diathesis, secondly certain exciting causes incident to the ingesta and surroundings of the person, and thirdly a catarrhal or inflammatory attack which acts as the direct cause of the deposit.

With reference to the treatment of an attack of renal colic, I may say that the advice commonly given, viz.: to administer belladonna, opium, diluents, etc., and to place the patient in a warm bath, with the application of wet cups or perhaps venesection, is utterly inadequate to relieve the frightful agony experienced during the passage of renal calculus along the ureter. I speak of what I know, having been myself a victim of the trouble in question, when I advise the administration of an anæsthetic in every case where the pain is severe. Authors generally say that occasionally an anæsthetic may be given. I would be rather inclined to say that one always must be given. Of course in addition, the treatment already mentioned may be employed with the exception of the blood letting which, to say the least, is entirely unnecessary.

As regards treatment to prevent the deposit of renal stone, what I have been in the habit of recommending is careful regulation of the diet and relief as far as possible of dyspeptic symptoms, the drinking of considerable quantities of water which

it is well to have as free from lime as possible ; frequent warm baths and the wearing of flannel next the skin ; plenty of out door exercise and the avoidance of beer and alcoholic liquors generally. As to medicine I have found nothing give so much relief as carbonate of lithia, in fact I have the greatest confidence in its value in cases of primary renal calculi or a tendency thereto.

### Correspondence.

#### COLLEGE OF PHYSICIANS AND SURGEONS vs. QUACKERY.

To the Editor of the CANADA LANCET.

SIR :—Last fall a quack named Jones came to these enlightened regions, where he remained, doing a first class business, leading the people to believe he had the proper authority to practice, until about a month ago when he suddenly decamped, taking with him the daughter of one of our wealthy farmers, who patronised and opened his house to him. This Jones styled himself “ J. r. Jones in the profession of roots and herbs, of Milltown, Ont.” I was perplexed at the credulity of the people who told me of his doings, but not wishing to bring him before a magistrate, I wrote to Dr. Pyne, who promised to send a detective down, but the said official came too late to catch his victim.

Jones had his board and lodging gratis among the people for nearly nine months, and is said to have made nearly \$3000. He is about 6 ft. in height, wears a light moustache, and has the features of a hardened and desperate wretch. The detective was much disappointed to learn of his escape, but as there was enough material of the same kind to work up, he had “ Dr.” Gardiner of Bannockburn arrested, and fined \$28. This man has practiced openly for over ten years in this county ; has charged four times more for his medicine than any qualified person, and is let go free for \$28. During the last ten years the College has exacted \$10 from me, to protect me as I understand it, but if I had followed the advice of medical friends, I would not have paid a dollar, for many of them believe the College to be a farce.

The way that quackery is allowed to flourish here, is not at all encouraging to those who are thoroughly qualified. and besides, it is derogatory to the good name of our time-honored profession. The

physicians here have quite enough to do to live respectably, and in many instances they have to establish drug stores, for the practice of medicine would not keep them above want. Yet these quacks who infest our neighborhood, charge just what they please, and collect where we fail. Such practices are a direct encouragement to young men contemplating medicine, to take the road as quacks. The fact is, people seem to have more confidence in the quack, than in the possessor of the M.D., M.R.C.S., etc., etc., and the former makes more money, has less care, and is about as respectable in the eyes of nine-tenths of the people of Canada. With a view to protect ourselves and the public, every physician should, whenever a quack is known to be in his midst, notify the representative of the district of the fact, in order that a detective may be put on his track. It should also be the duty and privilege of the registrar, to erase the name of any member who lends his name and influence, to any travelling concern whose tendency is to deceive the public. Whenever the representatives and the College unite, to protect those who have fulfilled every requirement, all grievances will cease and the profession will be re-instated on its proper level.

PRO ARIS ET FOCIS.

M—, July 20, 1885.

### Reports of Societies.

HAMILTON MEDICAL AND SURGICAL SOCIETY.

June 2nd, 1885.

The Vice-President in the chair.

Dr. McCargow exhibited the lower end of the femur of a man whose thigh had been amputated in the hospital by Dr. White. The patient, aged 36, had been admitted to the hospital with the following history :—At 14 years of age received a slight injury on the inner side of the thigh, while sleigh riding ; since then has had pain in the knee with swelling, chiefly during changes in the weather and in cold weather. Although knee has pained since the first with the exception of slight intermissions of a few weeks, he has never been confined to bed, and the only treatment has been in the form of external applications. Four months ago incisions were made and a large quantity of pus removed. When admitted, the lower half of



the right femur was found enlarged and hard. The swelling extended to the lower half of the right knee, and the patella was fixed: two openings had been made one on the outer, the other on the inner side of the thigh; the openings had partially closed, but there remained small sinuses from which pus discharged pretty freely. Patient was able to move about on crutches and was not confined to his bed in the ward. Family and personal history were both good, no record of anything specific. A longitudinal section of the bone was shown; there was an abscess cavity in the centre, with thickening and enlargement of the bone. The cavity was six inches long, one half inch wide, but irregular. The cartilage of the knee was intact. The diseased bone was twelve inches long altogether. Dr. Malloch said that when the section of the bone was made there was a piece of necrosed bone in the cavity which would account for the inflammation.

Dr. R. R. Wallace read a paper on "Incisions in Whitlow." Authorities were quoted to show the site of incision preferred. Erichsen recommended an incision on each side of the finger, while Fairlie Clarke advocated incision on one side; others preferred the median palmar: Keetley advised two palmar incisions. The essayist thought that incision in the median line over the ungual phalanx would be likely to divide the digital arteries as they there cross to form an arch, while the great argument in favour of the median incision had always been that it avoided such accident. He believed that in whitlow confined to the ungual phalanx, incision along the side, carried to the bone if necessary, is the best one to practice, for it affords exit to all pus and sloughs, and effectually relieves tension, thus removing the great cause of the agonizing pain, and avoiding at the same time a cicatrix on the most exposed portion of the finger where it impairs more or less the tactile sense. If the incision on one side was not sufficient, the double one should be practiced. When the disease had extended up the finger, and involved the sheath of the tendons, he thought there was no choice but to open the sheath and give exit to the pus, and this he considered was best done in the median line on the palmar aspect. With regard to the question of one long incision or separate ones between the joints, he thought that the arguments in favor of separate ones were

very strong, as there is less liability of causing strangulation over the shafts of the phalanges, and the tendons were not so much exposed or injured by the smaller incisions and the liability of sloughing lessened. Dr. Malloch expressed his surprise at the advocacy of the lateral incision. He said that Ashhurst recommended it because it avoided sloughing, but he himself had never seen it result from the median when incision was made early enough: the only difficulty was in keeping the incisions open, it being necessary to use the probe night and morning. The lateral incision, he thought, would go indirectly to the matter; there was no danger in wounding the arteries and nerves as they would heal readily enough. Other members who spoke all favored the median incision and a good free one.

The Vice-President, Dr. Stark, then showed a specimen, the first phalanx of the middle finger of the left hand. The history of the case was a blow followed by a swelling on the side of the finger, but not much pain; it was poulticed, but an incision was not allowed at first, and when opened it had to be done several times, and finally amputated, and was found to be much expanded, necrosis having evidently taken place.

July 7th, 1885.

The President, Dr. White, in the chair.

Specimens were shown by Dr. McCargow of two kidneys containing a number of gummatous growths, the following report being given of the case by Dr. J. Cochrane:—When the patient entered the hospital there was no history of syphilis to be obtained. Soon afterwards two growths like horns appeared on the forehead, evidently of a fibroid nature.—Afterwards chest symptoms appeared, there being effusion, which, after a small amount of fluid was withdrawn by a hypodermic needle, seemed to subside. There was also noticed a gradual hardening of all the glands of the body. Specific treatment was adopted but was of no benefit, the patient dying of exhaustion. Post mortem—there was thickening of the pleura and general adhesions; the cavity contained between eight and twelve ounces of fluid; there was also effusion into the pericardium. The left lung was healthy, but there was great fibroid thickening of the right, there being a fibrous band passing through it from pleura to pleura. Liver and spleen were healthy, but the kidneys were enlarged and congested and contained a num-

ber of large yellow gummata. The peritoneal glands were enlarged, while the glands of the groin were broken down. In reference to this case, Dr. Woolverton, under whose charge the patient had been, stated that at first she had indefinite pains in her legs; the growth on the right frontal region had increased in size up to the time of patient's death. Two months before, she began to have cough and continued elevation of temperature, the dulness extended rapidly and the chest was seen to be enlarged; after the exploratory aspiration the effusion seemed to decrease, and friction râles were heard, so further operation was postponed; the symptoms improved for a while, but afterwards enlargement again took place, and death at the last was rather quicker than expected. The disease of the lungs he considered to be syphilitic.

Dr. Malloch thought that it was a case of tertiary syphilis, and that the swellings on the scalp were not properly interpreted, for if their softness had been considered, they would not have been thought secondary, as they had been suspected to be.

The other specimens shown were a uterus with a growth attached to the fundus of the size of a strawberry, and two intermuscular growths, and a portion of cancerous liver. The history given by Dr. Cochrane was as follows: There were no definite symptoms at first except an inability to retain anything on the stomach, which was thought due to alcoholism; afterwards the condition of the liver was diagnosed. The patient's illness was not of long duration. Post mortem—the liver was found to weigh over five pounds and was studded with cancerous masses, some of them as large as half an orange. In regard to this case, Dr. Mullin inquired if there was any primary seat of the cancer, and was inclined to think it might be in the uterine growths. Dr. McCargow thought it was in the liver itself, and that all the symptoms pointed to malignancy. Dr. Mackelcan inquired if there was any ascites, as in his experience it was generally present in cancer of the liver. Dr. Griffin asked if there was any disease of the pancreas, but none had been observed.

Dr. Hillyer then read a paper on "Typhoid Fever," giving an account of an outbreak of an epidemic character which occurred in the county of Norfolk, in April, 1860. At the time there was a good deal of discussion as to the nature of the outbreak, some of the local physicians calling it typhus,

some pernicious, some typho-malarial, and others typhoid, there being such a variety of symptoms as to warrant the differences of opinion. The epidemic extended over an area of from 10 to 12 square miles, amongst a poverty-stricken and hardworking backwoods population. The disease was first noticed amongst lumbermen who had come from Illinois, where a similar epidemic had been raging. Out of five members in the first family attacked, the mother and three children died. The second family attacked were relations, and had visited the infected dwelling while they themselves lived in a one-roomed badly ventilated house. The symptoms presented by those attacked first were typical of the epidemic, and were as follows: epistaxis occurring early with decided chills, followed by fever, flushed and dusky complexion, accelerated pulse, furred tongue, and general feeling of languor and debility. After the first few days when there was an intermission, the fever gradually became continuous. Nervous symptoms also were present, viz: restlessness, aching of the back and limbs, headache and insomnia. The bowels were loose with the characteristic discharge. As the disease advanced, the pain increased in the right iliac region, abdomen became tympanitic, tongue dry, swollen and of a brownish color, which gradually increased to black. A petechial eruption appeared over the body, with sudamina on the neck and portions of the chest; black sordes appeared on the teeth and gums, and delirium with a general typhus condition supervened, while there was a pungent and penetrating odor from the body. The patients evinced great feebleness, while the skin showed great lack of vitality, sloughing taking place on blistered surfaces. Finally the pulse gave way and became excessively frequent and fluttering, the extremities cold and clammy, and the abdomen enormously distended. After referring to some cases which presented different symptoms, and more of a typhus character, there being no enteric symptoms, costiveness being present from the outset, while in others gastric symptoms were most prominent, he proceeded to speak of the contagiousness of the epidemic, instances being noted where those who had gone away to escape the disease had been stricken down with it, while on the other hand, those who had been constant in their attendance had in some cases escaped. Another feature of the epidemic spoken of, was, that for months, wherever its taint

extended, all forms of inflammatory action assumed an asthenic type, and typhoid symptoms were sure to develop. The writer then took up the nature of the epidemic, after which he gave an account of the treatment adopted. This was chiefly of an expectant nature with special treatment of an ordinary kind for the ordinary symptoms. A discussion followed, the general idea being that the epidemic was one of typhoid. Some conversation also took place on the question of what constituted typhoid fever, and whether it could exist without the special enteric symptoms.

#### NOVA SCOTIA MEDICAL SOCIETY.

This Society met at Halifax on Wednesday, June 17th, the President, Dr. Macpherson, of North Sydney, C.B., in the chair. Dr. Sinclair read an interesting paper on "New Remedies in Insanity and other Diseases of the Nervous System," and reviewed the evidence in favour of the four following remedies: 1. Paraldehyde. This drug was first introduced by Cernello, of Palermo, in 1882. It is formed from an aldehyde or dehydrogenated alcohol by the action of an acid, and has the formula  $C_6H_{12}O_3$ . When acted upon by chlorine it is said to be converted into chloral. It is a sedative and hypnotic, and its advocates claim that it has all the good qualities of chloral without its dangers. No nausea, depression or headache have been known to follow its free administration. The taste is disagreeable and difficult to disguise; the best vehicle is ice water in large quantity. The dose of paraldehyde is 3ss. to ʒi. Dr. Andrews, who had experimented largely with the drug, thought it supplied no demand not already met by other agents, which had their own advantages. 2. Nitro-Glycerine, or Glonoine. The theory of its action is, that it reduces arterial tension by paralyzing the vaso-motor nerves, thereby dilating the blood vessels. It has been recommended in angina pectoris, valvular disease, weak dilated heart, albuminuria, chronic Bright's disease, asthma, epilepsy, migraine, and some forms of insanity. Dr. Sinclair's experience both with this drug and with nitrite of amyl, was that in epilepsy the number of fits were increased. 3. Jamaica dogwood (*Piscidia Erythrina*). He used it in doses of fifteen minims to ʒij. of the fluid extract. As an hypnotic it failed but proved satisfactory as an anodyne. In the severe frontal headache of epileptics, one drachm doses either alone or in combination with bromide

of potassium or chloral produced unquestionable benefit. In two cases of dysmenorrhœa, relief of most agonizing pain was speedily obtained. 4. Hyoscyamine and hyoscine. The writer began his experiments with the crystals, using a solution in glycerine and alcohol, and giving it in doses of  $\frac{1}{6}$  to  $\frac{1}{4}$  of a grain. In acute mania he produced the full physiological effects, and even when its toxic effects were present only temporary quiet was produced. Pushed to this extent grave symptoms were produced, such as irregular pulse and respiration, congestion of the head and face, cyanosis and dryness of the mouth and fauces. The freshly made fluid extract of hyoscyamus in doses of ʒss. to ʒiiss. gave much better results. He has practically discarded the crystals. The amorphous hyoscyamine is essentially distinct from the crystals and consists of at least two crystallizable salts, and to this compound it is proposed to apply the name hyoscine. It is a feeble sedative to the spinal and respiratory nerve centres and a dominant hypnotic upon the brain. In doses of  $\frac{1}{100}$  gr. hypodermically it produces calm and sometimes sleep. Dr. Wood used it in nine cases of insanity with great violence and sleeplessness. In all cases quiet resulted and in some sleep, varying from 4 to 6 hours. He recommends it in asthma, whooping cough, and delirium tremens.

A discussion followed in which Drs. Parker, J. F. Black, Smith and Lindsay took part.

Dr. Farrell read a paper on "Excision of Joints," and gave the results of cases treated by him in the Halifax Hospital. Two patients were exhibited in whom the elbow had been excised with excellent results. The other cases referred to were, two of the knee and three of the hip. He laid great stress upon operating before suppuration began to discharge externally. For scrofulous arthritis, excision in almost all cases, is advisable. Under six and after forty the mortality is much greater than at intervening ages. Resection of the hip will be more frequently performed, the mortality being 25 per cent., when left alone 50 per cent.

An interesting discussion followed in which Drs. Muir, Macdonald, Stewart and Somers took part.

Dr. J. F. Black read a very interesting and lengthy paper on "American Medical Institutions," being notes taken in his recent visit to the hospitals of Montreal, New York and Philadelphia.

Dr. J. W. Macdonald read a paper on "Dynamite Accidents," with cases occurring in his practice as Medical Officer of the Steel Company of Canada. During the last five years he had found that an accident had occurred for every seven tons of the explosive used.

Dr. Dodge read an interesting paper on "Injuries of the Eye," with cases from his own practice. These cases were intended to illustrate various forms of injury to the cornea, iris and lens. Wounds of the cornea when made with a sharp cutting instrument were not necessarily serious, unless from their extent. When made with a rough irregular edge they were often very difficult cases to deal with. If the iris were wounded at the same time the injury was more formidable; and very soon severe inflammation led to more or less loss of sight, and if treatment were delayed for a few days total loss of vision frequently ensued. Wounds of the lens also often proved serious. Two very interesting cases were related in which a piece of metal was lodged in the iris; another a case of injury from gunpowder destroying the transparency of the greater part of the cornea, except the upper border, which was partly concealed by the lid. Iridectomy was afterwards performed and section of the superior rectus was subsequently made to uncover the clear portion of the cornea, allowing the ball to roll downwards and thus assist the sight. A case of wound of the cornea extending into the sclerotic was next given. A stitch was placed in the sclerotic and a good result followed.

Dr. Andrews read notes of a case of "Rupture of the Kidney," and Dr. DeWitt reported two cases of empyema successfully treated. Want of space prevents extended reference to these valuable papers.

Dr. A. P. Reed read a paper on "The progress of Medicine." Dr. Campbell on "Heredity as a Causative Influence in Progressive Muscular Atrophy." Dr. Moore on a peculiar case of "Mental Derangement due to Excessive Use of Alcohol." Dr. Stewart on "Physical Education," and Dr. Mackay (Reserve Mine), on "Cases of Obstetric Interest."

By a resolution of the Society Drs. Macdonald, Stewart and Mackay were requested to have their papers published.

The following officers were elected for the ensuing year: Dr. Stewart (Pictou), President; Drs. Sinclair and Mackay, Vice-Pres.; Dr. J. W. Macdonald, Secretary and Treasurer.

## Selected Articles.

### STRICTURE OF THE URETHRA.

The following cases of stricture of the urethra, under the care of Mr. Paul, Royal Southern Hospital, Liverpool, which we publish, are of interest, each of them being complicated and requiring special treatment. Wheelhouse's operation, which was performed in one case, was described by him in 1876; but, as Mr. Paul observes, it is not necessary to use the special instruments then brought forward, success being equally obtained with instruments which are in almost daily use.

CASE 1.—Josiah C——, aged fifty-four, a seaman, had suffered many years from stricture (he says thirty), but had never been treated for it. He sought admission on account of a perineal abscess. Under ether the abscess was opened, the stricture divided, and a full-sized gum-elastic catheter passed and tied in. On the third day the catheter came out and was not reintroduced, a Lister's bougie being passed daily instead. At the end of two months he was discharged almost well, but warned to attend as an out-patient for some time to get the bougie passed, as the stricture showed a strong tendency to contract again. He was an extremely nervous man, and once out of the hospital had not the pluck to continue treatment, the result being that in the course of a few months he had another urinary abscess worse than the first. He kept away from the hospital until he found that he was getting in a very bad way, when he returned in the following condition: the scrotum and the whole of the perineum and neighboring parts were brawny and tender. Just behind the former was a ragged, foul-smelling sore, eating deeply into the perineum along the tract of the original fistula. Its edges were hard and epitheliomatous in appearance, and upon scraping the surface of the sore the characteristic "nest cells" were found in abundance. The disease was too far advanced to permit of any attempt at removal, and came to a fatal end in about three months, the actual cause of death being cellulitis. At the post-mortem the growth was found to be limited to the perineum and neighboring glands, involving all the parts down to the arch of the pubis and spreading freely into the scrotum. The prostate and bladder were quite free.

*Remarks.*—I believe that this is a very rare sequence to a urinary fistula, and it is very unfortunate that there were no means by which the exact origin of the epithelioma could be determined. It is difficult to distinguish microscopically epithelioma of the bladder from epithelioma of the skin, and the same holds good with the urethra. The whole case lasted only ten months. When first seen, the skin of the perineum was unbroken, it was quite free from growth two months later,

and then, at the end of another five months, was the site of a large and very deep epithelioma. Under these circumstances, I inclined to the opinion that the growth commenced in the urethra, and was excited by the prolonged stricture; just as simple syphilitic stricture of the œsophagus sometimes ends in epithelioma of that structure.

CASE 2.—James P—, aged thirty-four, had gonorrhœa when a lad and had suffered from stricture for the last sixteen years. He had often been under treatment at the various hospitals in the town, but had never had anything larger than a No. 6 or 7 passed, except on one occasion when Mr. Harrison ruptured the stricture with Holt's dilator. After this he learnt to pass a catheter for himself, but had only used the smaller sizes, and came to the hospital, as he could get nothing more in and was scarcely able to pass his urine. On admission, he was in good general health. There was a cartilaginous stricture in the perineum which would just admit the smallest soft bougie. The urine was foul and contained a quantity of mucus. At the end of three days no dilatation had been effected with catheterism, and the bladder symptoms were becoming more urgent; Wheelhouse's operation was therefore performed at once. The patient was placed in the lithotomy position, and a long silver probe passed down to the stricture. An incision was then made on to the end of the probe, which was pushed out of the wound and bent into a hook. The sides of the urethra were held open with artery forceps, a grooved probe insinuated through the stricture, which was divided, and the probe passed on into the bladder. It was now quite easy to pass a full-sized Lister's bougie from the penis to the bladder; so the patient was sent back to bed without having a catheter tied in. At the end of a week the urine was quite clear and all irritation of the bladder had ceased; so, instead of the daily passage of a bougie, a large gum-elastic catheter was tied in. While the catheter was kept in all the urine came by it, and the wound healed rapidly. It was removed in ten days, and the patient taught to pass a No. 12 Lister's bougie, and discharged a few days later. Altogether he was in the hospital only from Jan. 12th to Feb. 7th.

*Remarks.*—I send this straightforward case for publication because I have so often felt the advantage of an early operation of this nature in stricture cases, and because I often notice that my surgical friends, while they laud the method advocated by Mr. Wheelhouse very rarely seem to adopt it. In the hands of specialists internal operations upon the urethra are much in vogue; at present I have never either split or divided internally a stricture, except in the penis, preferring in all cases where an operation is necessary to do perineal section. I think it is a pity that Mr. Wheelhouse recommends special instruments for

his operation, as it is quite as easy to do it with those always at hand; and, with all due deference to his opinion, I do not find his sound and gorget of any material assistance, while their absence might influence some to attempt a different method of giving the necessary relief to the patient. In this case a catheter was not tied in at once on account of the cystitis: and at the conclusion of the treatment I adopted my usual practice of teaching the patient to pass a large metal sound for himself. It is the only permanent cure for most strictures, though but few, of the hospital class at any rate, are wise enough to adopt it.

CASE 3.—James F—, aged twenty-seven, had gonorrhœa some years ago, but passed urine in a full stream until about twelve months back, when he had his first attack of retention of urine after a drinking bout. Since then, under similar circumstances, he has had three or four more attacks of retention, and at the same time the stream of urine has been steadily diminishing in volume during the intervals. On Feb. 2nd he was drinking, and on the morning of the 3rd was again attacked with sudden and complete retention. Relief had been attempted by catheter, and he bled profusely, but no urine was drawn off. He was admitted with the bladder moderately distended in the afternoon, and was in great pain. A metal catheter was passed into the urethra, but opposite the bulb left it for a false passage, and on withdrawing the instrument he at once strained away about an ounce of blood. Under these circumstances a morphia injection was given, and he was ordered to have a hot bath shortly, to be followed by hot fomentations to the abdomen, and further morphia if necessary. In the evening, though the treatment had given some relief, not a drop of urine had been passed, and it was therefore deemed advisable to puncture per rectum. The next day he was perfectly comfortable, and the urine was draining freely through the canula. On the 5th, after plugging the tube, he was able to pass urine by the penis, and it was consequently withdrawn. 6th.—Had a rigor, with nausea, headache, and diarrhœa. Temperature 104°. Ordered five grains of quinine every four hours. 7th.—Temperature fell below 100°, and became normal in a few days. The quinine was stopped on the 9th. 12th.—Soft bougies passed. No. 3 was the first to be gripped by the stricture, which was dilated to No. 6. 24th.—The patient was discharged with the stricture fully dilated.

*Remarks.*—In a case of this kind, I think the choice lay simply between aspiration of the bladder and puncture per rectum. I chose the latter entirely on account of the false passage. In acute retention, when, though the urethra is uninjured, no instrument can be passed, aspiration is called for, and will almost invariably not have to be repeated, since the relief afforded by it, together

with other suitable treatment, will permit the swelling and spasm of the urethra to subside, and in the course of twelve hours either the patient will have passed urine naturally, or it will be possible to introduce a catheter. But when a false passage is present, and it is extremely unadvisable to interfere with the urethra for a least a week or ten days, the better plan is certainly to adopt puncture per rectum, and retain the canula *in situ* until the power to micturate has returned. The pyrexial attack on the 6th I believe to have been due to some urine filtering into the false passage and permitting septic absorption, as no instrument was passed until the 12th, and no trouble of any kind appeared in connection with the rectal puncture. I am a strong advocate for early operation in all cases of obstruction to the outflow of urine, when that obstruction cannot be easily overcome by catheterism. We ought to remember that the kidneys are the only part of the urinary tract of vital importance, and, sooner than permit their structure to be damaged, a clean incision should always be made into the urethra or bladder, as the case may require. Sadly too often, while we are wasting time over a cartilaginous stricture with small bougies, pyelitis is grafted on to cystitis, and suppurative nephritis may develop at any moment, and show too late the danger of delay.—*Lancet*.

**A CASE OF TRAUMATIC ANEURISM.**—In the *New York Medical Journal* for May 23rd Dr. Theodore McGraw of Detroit relates an interesting case of traumatic aneurism of the subscapular artery. The patient was a Pole twenty-seven years of age, who received three stabs about the shoulder in December, 1881, one of which was followed by an enormous extravasation of blood that was in due course absorbed. Three years later he came under Dr. McGraw's care with a rapidly growing pulsating swelling in the axilla, which had all the usual characters of an aneurism. There was no alteration of the radial pulse. Its increase in size was so rapid that treatment had to be resorted to at once. The first step of the operation was to make an incision above the clavicle, through which the subclavian artery could be compressed. A free incision was then made over the tumour, and carried through the pectoralis major muscle, and attempts were made to detach the thick sac of the aneurism from the surrounding structures. When this step of the operation was about half completed, the sac ruptured, and thinking that the attempt to isolate it must be abandoned, the sac was freely laid open, and the mouth of the artery controlled by the finger; but after many efforts it was found quite impracticable to free the mouth of the artery and to throw a ligature around it, for the sac was formed of very dense tissue, and was firmly adherent around the wounded artery. Dr. McGraw thereupon returned to his original plan, and

with ease separated the fundus of the sac from the ribs and the anterior and posterior walls of the axilla, and then ligatured its neck. After this the axillary artery was with comparative ease freed and tied above and below the origin of the subscapular branch, which was found to open into the aneurism within half an inch from the parent trunk. Arguing from this case, Dr. McGraw advises that while Syme's operation is suitable for cases of ruptured artery, it should not be adopted for traumatic aneurism where there is a well-formed sac. It is pointed out that it may be impossible from the interior of an aneurism to free the artery sufficiently to ligature it without imperilling contiguous arteries, veins, or nerves, while the detachment of the sac may be a comparatively easy and rapid procedure if done systematically. A ligature can then be tied around the neck of the tumour, and all danger of hemorrhage avoided, and if the fundus of the sac be cut away the field is comparatively clear for the final steps of the operation. It is undoubtedly a dangerous and difficult matter to clear an artery from the inside of the sac of an aneurism, and where the sac is sufficiently dense to permit of it, the plan of operating proposed by Dr. McGraw offers decided advantages.—*Lancet*.

**THE USE AND ABUSE OF THE TAMPON IN ABORTION.**—The tampon as a means of arresting hæmorrhage from the cavities of the body or from wounds has been known to the profession for many years. It seems a very natural thing, when blood is escaping with dangerous rapidity, to apply a plug of some sort to stop the leak. There are some things to be guarded against, however. That the bleeding is actually arrested, and not merely diverted into another channel, is of primary importance. Again, there are conditions in which the plug may do mischief. As applied to uterine hæmorrhages, these two elementary principles are so well known that no one will question the correctness of either. A woman with the vagina firmly plugged may bleed to death into the cavity of the uterus. A tampon allowed to remain too long may do harm in various ways. A tampon injudiciously applied may precipitate the catastrophe it was intended to avert. Of this injudicious application of the tampon in cases of threatened abortion it is the purpose of this paper to treat.

Dr. Keene then quotes the views of Leishman, Playfair, Tyler Smith, Cazeaux, Shroeder, Lusk and others and says: Now, out of this mass of authority, sometimes conflicting, but generally unanimous, what deductions are to be drawn? That the tampon is to be used as a last resort, and only where the hæmorrhage is dangerous or the abortion clearly inevitable. We have, moreover, the observation of so experienced an obstetrician as Shroeder, that the hæmorrhage of abortion is seldom dangerous and scarcely ever fatal—a view which

Lusk seems to share. Of course, in their hospital experience, a physician is always at hand to meet any emergency, while in private practice, and especially in the country, another condition of things prevails. Yet it seems that enough has been said to indicate plainly that the routine practice of plugging, in threatened abortion with but slight hæmorrhage, merely as a precautionary proceeding, has no countenance from the authorities.

Besides the natural bias of the physician's mental makeup—his individual personal equation—his views will vary as his experience has been large or small. To a beginner, the loss of a slight amount of blood from the uterus of a pregnant woman is fraught with direful forebodings. As his experience widens, hæmorrhage will become dangerous less frequently, abortion will take its place under the inevitable class with much less facility, and the tampon will be employed only to fulfil its two legitimate indications.

The young practitioner is not the only offender in the over-free use of the tampon. His older brother may well look to the well-worn grooves in which his practice moves more or less smoothly to discover whether he, too is not a devotee of the tenet that the fœtus has no rights which the physician is bound to respect. The tampon is legitimately employed only when for good and sufficient reasons it is necessary to terminate gestation.—*Dr. J. W. Keene, New York Med. Journal.*

**CONFESSION NO PROOF OF GUILT.**—The *Lyon Medical*, of April 28th, 1882, refers to the case of a girl, aged twenty, supposed to be seven months pregnant. After an attack of hæmorrhage, her size seemed to have considerably diminished; and the girl being closely questioned on the subject, said that, becoming aware of the discharge, she repaired to the closet, where she stayed ten minutes. She added that all had escaped, but that she had not time to look, as she was being called by her mistress. A midwife and the parish surgeon both declared that the girl had been recently confined. She was now again assailed with questions, and told that, for her own sake, she had better make a clean breast of it, as no fœtus had been found in the closet. Perhaps, it was suggested, she had thrown it into the pigsty. The poor creature at first denied such a thing, but at last confessed that it was so. A search was made but no child was discovered. She was tried for concealment of birth, on her own confession, and sentenced to six months imprisonment. The girl had not been taken into custody in consideration of her free confession, and she quietly proceeded to the goal. When admitted, it was found that she was far advanced in pregnancy, and soon gave birth to a healthy girl. By the French law she could no longer appeal, as more than ten days had elapsed since the verdict; but the judge, having the power of appealing within two months, did so, and the girl was acquitted.

This case shows that confession, which is looked upon as the clearest proof of guilt, can not always be relied upon. And what shall we say of the surgeon and midwife? The examination was probably hurried and incomplete, and the conclusion arrived at on seeing the signs of recent abundant hæmorrhage. This case, even in a simple obstetrical point of view, is full of valuable hints.

**TREATMENT OF HEMORRHAGE AFTER OPERATIONS ON THE RECTUM.**—Mr. Samuel Benton (*British Medical Journal*) brings to the notice of the profession a useful instrument for checking hæmorrhage after rectal operations. It consists essentially of a piece of catheter tubing surrounded by a bag of thin rubber. When introduced into the rectum, the rubber bag is inflated to any extent required, and so a considerable amount of pressure may be brought to bear on the bleeding surface, in the same way that a similar apparatus is used for the relief of epistaxis. Mr. Benton's bag is constricted in the middle (like a Barnes' bag), so the amount of pressure on the sphincter will not be too severe. The catheter tube, by allowing the escape of flatus, contributes much to the comfort of the patient. The inventor considers that, in addition to its use as a hæmostatic, it will prove serviceable in the treatment of some rectal diseases where even pressure is indicated, as in non-malignant tumors of the rectum.—*Annals of Surgery.*

**ENDOCARDITIS.**—When endocarditis is found to be present, Dr. C. Paul, *L'Union Méd.*, applies a large blister over the region of the heart, orders rest, and prescribes some cool acidulated drink. If the disease occurs with articular rheumatism and sali-cylate of soda or sulphate of quinine is found efficacious, its use is continued as long as the pulse is not too rapid and irregular. If, however, the heart's action is disturbed, tincture of digitalis is to be given in doses of twenty drops twice a day, and gradually increased to sixty or eighty drops. The dose should not be increased until two days have elapsed, and as soon as the heart's action becomes regular the remedy may be diminished in quantity or suspended. The tincture of convallaria maialis, in doses of seventy-five minims per diem, may be given in place of the digitalis. As soon as the pulse becomes regular, recourse must be had to tonics, and especially the soluble ferruginous preparations.—*N. Y. Med. Record*, May 23d.

**BRONCHITIS WITH VALVULAR HEART DISEASE.**—Prof. Bruen, Phila., at his clinic, speaking of such a case, said:

My own experience in the treatment of simple bronchitis has been that the expectorants designed to increase secretion of the bronchial mucous membrane may be at first freely given; but their



use should not be prolonged, but should soon be substituted by the stimulative expectorants. I have found that if the bronchitis is not rapidly cured by these, but passes into a subacute condition, more can be accomplished by building up the general strength than by acting on the bronchial mucous membrane directly. In cases of cardiac bronchitis a great deal can be accomplished by building, not only by acting on the heart directly, but also by the use of such drugs as strychnia, arsenic, and iron.

We shall prescribe for this man the following pill :

R	Strychniæ sulphatis,	
	Acid. arseniosii	aa gr. ss.
	Pil. ferri carb.	grs. xxiv.
	Oleo-resinæ capsici	gtt. vj.
	Extracti gentian	grs. xij.

M. et. ft. pil. No. 24.

Sig.—One, three times a day.

AN especial reason for using strychnia is that it increases the depth of the respirations, and thereby facilitates oxygenation of the blood, which is interfered with by the weak heart.—*Med. & Surg. Rep.*, May 23rd.

**HAY FEVER AND ITS TREATMENT.**—In this connection we may call attention to the new work of Dr. Sajous on "Hay Fever and its Successful Treatment." According to his views, hay fever would exemplify that form of asthma which Curschmann has never met,—the form in which the cause resides in the brain and nervous paths which lead from the brain to the respiratory apparatus. For, according to Dr. Sajous, persons subject to hay asthma possess, as the result of heredity, diseases implicating markedly the nervous system, nerve centres which have become abnormally sensitive and are therefore inordinately influenced by the external irritants to which they respond. But this is not the whole of the pathology of hay asthma, according to Dr. Sajous. Not only must there be a hyper-excitability of the nerve centres, but the nasal mucous membrane must be hyperæsthetic, and capable of transmitting to the abnormally sensitive nerve centres the impression made upon them by external irritants, which are supposed to be the pollen of flowers and certain other unknown elements which prevail only from June to September. Given the absence of any one of these conditions and the patient is spared the attack. The absence of the physical element, whatever it may be, which causes the irritation may be secured by removal to certain localities where it does not prevail.

Dr. Sajous secures the removal of the irritable mucous membrane by eliminating, first, the abnormal conditions of the mucous membrane, that is the swellings, hyperostoses, etc., by suitable treatment: and second, by cauterizing the hyperæsthetic nasal mucous membrane, and thus rendering it in-

susceptible to the irritating agencies. This is the new and successful treatment of hay asthma, in the early use of which Drs. W. H. Daly, of Pittsburg, J. A. Roe, of Rochester, and Prof. Harrison Allen, of Philadelphia, have, also, been conspicuous. We sincerely hope that further experience may confirm these preliminary statements, and that "hay" or "rose" asthma may no longer be the opprobrium it has always been to the science of medicine—*Med. News*.

**COCAINE IN BURNS.**—Dr. Weiss writes:—On December 25th, I was called to Professor L—. An atomiser he was using had exploded, and the hot steam badly scalded the Professor's lips, nose, cheeks, and forehead. Pain was so intense that I apprehended general convulsions. I sent for sundry topical remedies, amongst them a two per cent solution of hydrochlorate of cocaine. In the meanwhile I covered the injured parts with pieces of cloth dipped in olive oil; on the top of these I applied ice water compresses, renewing them every minute, without affording the slightest relief. When the medicaments arrived, I touched the injured parts with a hair-pencil dipped in the cocaine solution. I had scarcely finished when all pain had entirely vanished, without any return. At my visit in the evening I found the patient quite easy and in good spirits.—*Wiener med. Woch.* Jan. 8, 1885. [It is also useful in the treatment of sore nipples.]

**AN INGENUOUS EXPEDIENT.**—Recently I was called to examine a woman who has had vesicovaginal fistula for years. The sufferer has kept herself cleanly and comfortable by using in the vagina a globular pessary made of compact sponge. The fistulous opening is near the urethral outlet; and the pessary holds the false orifice so high that the urine can be retained for hours. The patient never urinates, but evacuates the bladder every three or four hours through the agency of a catheter—an instrument she has become expert in using. The expedient might possibly be adopted in some cases where an operation for closure of the rent is not practicable. I commend the ingenuity of the woman who, unaided by even a professional suggestion, has kept herself from being offensive to herself and others.—*Eclectic Medical Journal*.

**ENTERITIS CAUSED BY CORROSIVE SUBLIMATE.**—Dr. J. L. Peabody read a paper recently before the Practitioner's Society of New York, on toxic enteritis caused by corrosive sublimate as a surgical dressing. Attention was first directed to this by reports of cases found in German medical journals. In the records of the New York Hospital eleven cases were recorded in which an obstinate diarrhœa followed the use of sublimate as a surgical dressing. Seven of these proved fatal. Autopsies in three of them showed extensive diphtheritic inflammation of the large intestine.

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet," Toronto.*

**AGENTS.**—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

TORONTO, AUGUST, 1885.

*The LANCET has the largest circulation of any Medical Journal in Canada, comprising four-fifths of the entire Medical Profession.*

## INTERNATIONAL MEDICAL CONGRESS.

Our readers are already aware that it is intended to hold the International Medical Congress in Washington in 1877. A committee of arrangements consisting of seven members, with power to add to its numbers, was appointed at the meeting of the American Medical Association in 1884, to extend an invitation to the Congress to meet at Washington, and in case of an acceptance, to make all necessary arrangements for the meeting and to solicit funds for that purpose. This committee was composed of Drs. Austin Flint, Sr., and L. A. Sayre, New York; I. Minis Hays, Philadelphia; C. Johnson, Baltimore; H. F. Campbell, Georgia, and J. S. Billings and J. M. Browne, of the U. S. army and navy respectively. The invitation was accepted, and to this committee about twenty additional members were added, among others, some "new code" men of note, and a meeting was held in Washington and a plan of organization adopted. The list of officers, and numbers of sections (nineteen in all) were published in the medical journals of the United States and foreign countries, and met with general approval. Everything went smoothly as a marriage bell until the meeting of the American Medical Association in New Orleans in May last, when a few turbulent spirits of the "rule or ruin" type, to be found in all assemblies, took exception to the action of the committee on the ground, first,

that it had recognized "new code" men; and, secondly, that the south and west were not fairly represented in the Congress, the majority of the officers having been chosen from among the eminent names in the East—New York, Boston and Philadelphia. "New code" prejudices and local jealousies were too much for the serenity of the Association, and the upshot was the appointment of a mammoth committee of 38 members, representing every State and Territory in the Union, Army, Navy, etc., to be added to the original committee, with power to alter or amend the action of the former committee, as it might deem best. This committee met in Chicago on the 24th of June, and, as might have been expected, there was a lively time. Only two members of the original committee put in an appearance, viz., Drs. J. S. Billings and I. Minis Hays, while twenty-four of the new members were present. Dr. Cole, of California, was appointed chairman, and Dr. Shoemaker (one of the leaders in the crusade against the original committee) was appointed secretary. The committee then proceeded to the work of revision. They first deposed Dr. Bowditch, of Boston, from the vice-presidency of the Congress, because of alleged "new code" sympathies. The following chairmen of sections ("new coders") were also deposed, viz., Dr. Noyes, on Ophthalmology, Dr. Lefferts, on Laryngology, and Dr. Jacobi, on Diseases of Children. The nineteen sections were reduced to sixteen, and the membership of the Congress was confined to delegates from the American Medical Association and societies in affiliation with it, thus excluding all from the Congress who are not in full sympathy with the American Association, and carrying the "code" quarrel into the Congress. When the result of the committee's deliberations became known, meetings of those interested were held in Boston, New York, Philadelphia, Baltimore and Washington, and resolutions were passed expressive of disapproval of the action of the committee, and refusing to have anything to do with the Congress under the present regime.

This action on the part of the leading members of the profession seems a most serious step, but it arises from the fact that there is a growing want of confidence in the ability of the American Medical Association, as an organization, to carry out such an undertaking satisfactorily, and also in the pro-

able success of any Congress from which the best known scientific men of the country are excluded. The action of the committee in regard to the "new code" men would indeed be ludicrous were it not so serious, and will have the effect of creating sympathy, where before there was only cold and formal respect. The insult offered to such veterans as Bowditch, Fordyce Barker, Draper, Weir, Mundé, Roosa, Knapp, Noyes, Agnew, Jacobi, and others, merely because of a difference of opinion on the code question, will not be tolerated by the good sense of the American medical profession.

We presume matters will probably remain in *statu quo* until the next meeting of the Association in St. Louis, when the whole question will be gone over again. We have faith in the good judgment of the medical profession, and believe that a way will be found out of the confusion and complication into which this matter has drifted.

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#### SUICIDE AND THE MEDICAL PROFESSION IN ILLINOIS.

The oft-repeated remark, that doctors carry on their shoulders more than a full share of the troubles of this life, finds a curious confirmation in the last necrological report of the Illinois State Board of Health. In this report are to be found a few unpretending figures, which, upon a more careful examination than that bestowed by the compiler, are found to be full of meaning and melancholy interest. It is to be hoped that in its next report the Illinois State Board of Health will supplement its figures by as full information as possible regarding some important points touching that part of their report to which we call attention. In this report it is stated that 202 physicians died during the previous year in Illinois. Of this number, six are reported as having died from suicide, five from "overdose of morphia," and two from "overdose of chloral." The reported suicides form about three per cent. of the deaths, a percentage in itself out of all proportion to what obtains amongst other classes of the population. But in addition, seven deaths are reported as having occurred from overdose of morphia and chloral—or over three per cent. of the total deaths. We all know that suicides take place which are never reported. Relatives and friends have numerous motives for suppressing

the facts. This is comparatively easy in the case of invalids or chronic drinkers, especially when sedatives are the weapons of self-destruction resorted to. If this be true as regards the general public, it is much more so as regards medical men, who have every facility for quietly ending their own lives in this way. In the report before us it is not stated that a single physician died from the careless or accidental use of any other poisonous agent. This looks suspicious. Of course medical men, like other mortals, have aches and pains to soothe, and suffer from insomnia, but that is no reason why they should kill themselves in greater numbers than they do their patients. The unvarnished truth is, that the "overdose," as regards the seven cases above mentioned, was simply the invention of friends interested in suppressing the real facts. If we allow two deaths by overdose, which is quite enough, that will make eleven deaths by suicide, instead of six as reported. We cannot be far astray in our estimate of the "overdose" cases in this instance, but when we come to estimate the number of unreported suicides we have entered the field of conjecture, and each one will have his own opinion. No one will deny but such occurred, while many will be apt to conclude that the number is relatively considerable. In the instance before us we shall suppose that three such cases occurred. That will give us fourteen suicides out of 202 deaths, or about seven per cent. Where so many suicides take place there must be a great many in the profession living in a state of utter misery and despair.

In this country we feel thankful to be able to say that no approach to such a condition exists. It is rarely, indeed, that a medical man in Canada dies by the act of his own hand. It would be interesting to know something of the professional standing and habits of these Illinois suicides, for that would afford some clue as to the cause or causes of a condition of things which we hope is exceptional, even as regards the other States of the Union. In this country insanity and drink are regarded as almost the sole causes of suicide in the case of medical men, especially the latter cause. But the native American is temperate, and we are assured that the great majority of American doctors are total abstainers. Drunkenness, therefore, cannot be said to be the most important factor. The most fruitful cause, most probably, is the over-

crowding consequent upon a low standard of general and professional education, or the absence of any standard worthy of the name. In the United States there is one doctor (so called) to every 600 of the population, and Illinois has its full quota, although it has rid itself, through the aid of recent legislation, of a large number of its quacks. The better element, under the new law, is forcing quackery into the background, and as a consequence we may safely assume, the most incompetent find themselves in desperate straits as the people become informed, and as medical men in increasing numbers become better educated, both in a literary and professional sense, so as to take a higher stand—not only professionally, but socially as well—the harder will be the lot of the poorly qualified and the mere charlatan. Perhaps, after all, it is better for society that these should continue the process of self-destruction than go on taking the lives of others.

The profession in Ontario, no less than the people at large, have much to be thankful for. Here no one can publicly practice who has not been found qualified after strict examination. This examination is not made by distinct schools, colleges or authorities, but by appointment of a central and independent authority called the Medical Council. This Council not being the creation, and hence not the creature of any existing authority save the law that constituted it, but a true representation of the profession by fair and open election, and as it is clothed with unlimited power, both as to the preliminary and final fitness of candidates, no one need fear that the standard will ever be too low or that the ranks will ever become much more crowded than they are. When undue overcrowding does take place, the remedy lies in raising the standard, and this power lies in the Council. No country can show brighter, better educated, or more able men in all respects, than the United States of America, yet, owing to imperfect laws, or the absence of all law, no country is so overrun with uneducated and half-educated doctors. Year by year the lot of the mere pretender will become harder and harder. All over the Union restrictive laws are fast replacing "free trade," and everywhere education and professional skill are becoming more and more in demand.

In view of these and other facts which might be mentioned, it is the duty of every one of us to

stand firmly by our privileges, to hold them fast, and to support our representatives in the performance of their duties by a cheerful compliance with the reasonable demands made upon us. The medical men of any State in the Union, would only be too glad to tax themselves ten times the amount asked of us for like privileges and immunities.

CANADA MEDICAL ASSOCIATION.—We would specially direct our reader's attention to the notice of meeting of the Canada Medical Association in our advertising pages. It will be seen that on application to the general secretary, Dr. Stewart of Montreal, all regular members of the profession will be furnished with certificates entitling them to purchase tickets at reduced railway rates. We are pleased to learn that the number of papers already promised is a sufficient guarantee that the Chatham meeting will fully equal its predecessors not only in the number, but also in the high value of its communications. The following are the officers of the Association—President, Dr. Osler of Philadelphia; General Secretary, Dr. James Stewart, Montreal; Treasurer, Dr. Charles Sheard, Toronto; Vice-Presidents, Drs. Bray of Chatham, George Ross of Montreal, Allison of St. John, Fraser of Windsor and Whiteford of Winnipeg. Local Secretaries, Drs. Burt of Paris, Bell of Montreal, Walker of St. John, Almon of Halifax, and Mewburn of Winnipeg.

COCAINE IN HAY-FEVER.—Now that the season for hay-fever is upon us it may not be out of place to state that great benefit has been obtained by a number of observers from the use of cocaine. Among others Dr. Watson of the Westminster Hospital, London, Eng., gives an account in the *Lancet* for July 4th, of the benefit obtained by him from the use of tablets of cocaine. The tablet which contains  $\frac{1}{6}$  of a grain of muriate of cocaine is moistened in the mouth and one introduced into each nostril. They adhere without difficulty and give immediate and complete relief. Menthol in alcohol solution has been used by some as a substitute for cocaine, but is not so lasting in its effect.

CHOLERA INOCULATION.—The French commission has returned home disgusted with Dr. Ferràn's inoculation experiments. He positively refused to allow the commission to carry off a single bit of vaccine matter, or to make known his method of

preparing it. His laboratory is poorly equipped, possessing none of the modern appliances, not even an apparatus for regulating the temperature of the stove in which the cholera virus is cultivated for attenuation. He told the commissioners that he could not surrender his secret without a "guarantee." Dr. Ferràn's whole course of action creates the suspicion that he is either a deluded scientist or a humbug, or both.

**PERSONAL.**—Dr. W. F. Coleman, formerly of St. John, N. B., has finally settled in Chicago. The following resolution was unanimously adopted by the St. John Medical Society, on his removal from St. John.

*Resolved*, That this society give expression to their high appreciation of Dr. Coleman's scientific attainments, gentlemanly bearing, and untiring professional zeal. While deeply regretting the loss that the society and the profession will sustain by his removal, we confidently predict for him a very large measure of success in his new sphere, believing, as we do, that he possesses all the elements of a first class practitioner.

JAS. H. GRAY, M.D., *President*.

T. M. MUSGROVE, M.D., *Secretary*.

**NEW METHOD OF COMPRESSING THE SUBCLAVIAN ARTERY.**—Dr. Joseph Bell exhibited before the Med-chirurg-Society, Edin., (*Lancet*, June 13, '85), a case of amputation of the arm for extensive sarcomatous disease of the scapula. The hemorrhage had been controlled by a method recommended to him by Prof. Chiene, in which a curved steel skewer was passed from above downwards behind the subclavian trunks, and brought out in front through the pectoral muscles. Pressure was exerted on the vessels by an elastic tube applied as a figure-of-8 over the anterior part of the region transfixed, a firm pad intervening between the elastic tubing and the patient's skin. The method is similar to that used by the late Prof. Spence in the case of the femoral artery in amputation at the hip-joint. In this case Dr. Bell found the method perfectly satisfactory, as the limb was removed with the loss of but two ounces of blood.

**CARBUNCLE.**—Dr. Bulkley read a paper before the American Medical Association on this subject. He is strongly in favor of allowing a carbuncle to break naturally. He contends that when a carbun-

cle is incised there is more danger of pus being absorbed. He also opposes poultices. He gives sulphite of calcium, in quarter-grain doses, every two hours; sulphate of magnesia, in laxative doses, three times per day, and tonic doses of sulphate of iron. He also makes an application to the carbuncle of solid extract of ergot, two drachms; oxide of zinc, one drachm; and two ounces of rose-water ointment. The preparation is spread upon lint and applied directly. He thinks this reduces pain and cuts short the disease.

**DIAGNOSIS OF GONORRHOEA IN THE FEMALE.**—The differential diagnosis between gonorrhœa and simple vaginitis, is usually not an easy task. It has recently been asserted, however, by M. Martineau, of Paris, that the pus of gonorrhœa is acid in reaction, while that of simple vaginitis is alkaline. If this be true, a piece of litmus paper will invariably determine the true nature of the case. The test is easily applied, and if reliable its importance is very great.

**AMALGAMATION OF MEDICAL COLLEGES.**—The Detroit Medical College and Michigan College of Medicine have been recently consolidated, and will begin their first session's work on the 23rd of September next. See announcement in another column.

**CORRECTION.**—In the article on Intra-Uterine Medication, by Dr. Temple, in our last issue, an error crept in on page 321, eighth line from top, in first column. It should read *one drachm* instead of one ounce.

**APPOINTMENTS.**—Dr. Wm. McClure has been appointed Medical Superintendent of the Montreal General Hospital.

The *Canadian Practitioner* expresses the hope that the question of "consultations with Homœopaths" will be discussed by the Canada Medical Association at the meeting in Chatham. We can assure our sanguine contemporary that the Association will do nothing of the kind. Moreover, we do not believe that it can be satisfactorily proven that members of the Association are "in the habit of consulting with homœopaths and other irregular practitioners."

We regret to announce the sudden and unex-

pected death of the wife of Dr. C. W. Covernton, of this city, in the sixty-sixth year of her age. She will be greatly missed by her large family and a numerous circle of friends. The doctor and family have our deepest sympathy in their sad bereavement.

**COMPOUND FRACTURES.**—Dr. W. P. Verity, of Chicago, read a paper before the American Medical Association on the "Treatment of Compound Fractures by Wiring and Drainage." In all cases of compound comminuted fractures coming under his care, he first cleansed the parts and removed all loose fragments likely to produce irritation. He is, however, opposed to removing any fragments that can be wired, as they are needed for support. All the sharp edges should be removed and the bones firmly wired together, and free drainage provided for by large drainage-tubes. The limb should then be covered with antiseptic dressing and incased in a plaster cast, which should be removed at each dressing. The advantages claimed for his treatment are that there is no shortening, union is more rapid, and no extension is required.

**CHRONIC CERVICAL ENDOMETRITIS**—Dr. T. Gaillard Thomas speaks highly of the following in this affection :

R	Magnes sulphatis,	3 ii ;
	Ferri sulphatis,	gr. xvi ;
	Acid. Sulph. dil.,	5 i ;
	Aquæ,	O i ;

M.

Sig. Two tablespoonfuls in a tumbler of ice-water daily on risidg.

Dr. RYERSON, of Toronto, acting surgeon of the Royal Grenadiers, who has been away with the North-West expedition, has returned and resumed practice. The Dr. was through the Fish Creek and Batoche engagements, and the subsequent operations of Gen. Middleton's column.

We beg leave to call attention to the elegant inset of Hazen Morse in this and last issue of the LANCET. His preparations have been before the profession for several years, and are constantly growing in professional favor.

Mr. John Eric Erichsen, author of the work on Surgery which bears his name, and Mr. Ernest Hart, editor of the *Brit. Med. Journal*, will be

candidates for Parliamentary honors at the next election.

The McIntosh Galvanic and Faradic Co. have been awarded the Gold Medal at the New Orleans Exhibition.

## Books and Pamphlets.

**CHOLERA** : Its origin, history, causation, symptoms, lesions, prevention, and treatment. By Alfred Stillé, M.D., LL.D., etc., etc. Philadelphia : Lea Brothers & Co.

Professor Stillé has contrived to compress into a little octavo of 162 pages all that he has felt called upon to say in relation to the absorbing subject of Asiatic cholera. He is a very decided contagionist. This doctrine seems to be as much favored now, as fifty years ago it was centemned. The logic of stern facts has been too powerful for the fancies of optimistic doctrinaires, and medical men of the present day have awakened to the old fact that two and two make four, and that no quantity of nonsense, added to an unknown quantity of baseless assumption, will be the equivalent of ever so fractional a part of truth. Dr. Stillé may be said to have been on the best terms of authoristic concordance with the writers of the May volume of W. Wood & Co. ; in fact they so reciprocally borrow and lend that they must all be on terms of close amity ; but it is not always easy to say which party is the borrower, and which the lender. We must however be so just as to instance one exception to this mutuality. Dr. Stillé deals rather sternly with Dr. Sternberg's adopted comma bacillus. He says : " It seems no longer possible to accept the bacillar doctrine of the production of cholera." In support of this negation he quotes Koch, on the mortality of the comma bacilli, where he has been so frank as to tell us, that, " even after three hours drying every vestige of life has disappeared." What ! so fearfully killing, and yet so easily killed.

**A PRACTICAL TREATISE ON URINARY AND RENAL DISEASES, INCLUDING URINARY DEPOSITS.** Illustrated by Numerous Cases and Engravings. By William Roberts, M.D., F.R.S., F.R.C.P. (Lond.), Professor of Medicine at the Victoria University, etc., assisted by Robert Maguire, M.D., Lond., F.R.C.P., etc. Fourth Edition. Philadelphia : Lea Bros. & Co. ; Toronto : Vanevar & Co. Price, \$3.50.

The work before us is one we can recommend to those in need of a good reliable work on the

above named subject. It is already well known to the profession through former editions, and has been highly appreciated. The work is divided into three parts. The first part takes up the physical and chemical properties of the urine, in health and disease, and the methods of examining the same chemically and microscopically. The second part treats of "Urinary diseases" viz., diabetes, gravel, calculus and chylous urine, in which the author not only gives the results of his own experience, but also all recent accepted facts in connection with these diseases. The third and most valuable part is devoted to the consideration of organic diseases of the kidneys, acute and chronic. The entire work is of a clinical and practical character, and will be found a reliable guide in the treatment of these diseases.

**BODILY DEFORMITIES AND THEIR TREATMENT, A HANDBOOK OF PRACTICAL ORTHOPÆDICS**, by H. A. Reeves, F.R.C.S. Eng., London Royal Orthopædic Hospital, with 228 illustrations. Philadelphia: P. Blakiston Son & Co. Toronto: Willing & Co., \$2.25.

The author deals with his subject in a most thorough and comprehensive manner, and gives us the full benefit of his large and extended experience in the treatment of this class of affections. Some subjects quite new to British surgery will be found in this book, for example, "Spring Finger, Paralytic dislocations, new operation for Nasal Depression etc. The work has been written from the standpoint of a general surgeon interested in this special domain, and the author endeavors to show that success in the treatment of orthopædic cases depends very largely on extensive experience, personal supervision, and watchful care.

**HAND-BOOK ON THE DIAGNOSIS AND TREATMENT OF SKIN DISEASES**, by Arthur Van Harlingen, M.D., Prof. of Skin Diseases; Philadelphia Polyclinic etc. Philadelphia: P. Blakiston Son & Co. Toronto: Willing & Co. Price \$1.75.

The above will be found a useful little work on skin diseases, adapted to the wants of the general practitioner. It is chiefly devoted to the clinical features, diagnosis and treatment of the various diseases. The diseases are taken up in alphabetical order, in order to facilitate ready reference.

**THE OLEATES, THEIR NATURE AND ACTION**, by J. V. Shoemaker, A.M., M.D., Prof. of Dermatology, Jefferson Medical College. Philadelphia: F. A. Davis, att'y. Toronto: Willing & Co.

**SURGICAL PATHOLOGY**, by A. J. Pepper, F.R.C.S., St. Mary's Hospital, London.

**SURGICAL DIAGNOSIS**, by A. P. Gould, F.R.C.S., Middlesex Hospital, London.

**THE DISSECTOR'S MANUAL**, by W. B. Clark and C. B. Lockwood, F.R.C.S., St. Bartholomew's Hospital.

**INTESTINAL OBSTRUCTION AND TREATMENT**, by Fred. Treves, F.R.C.S., London Hospital.

The above together with a work on *Materia Medica*, by Mitchell Bruce, constitute a series of clinical manuals for practitioners and students of medicine, published by Lea Bros. & Co., Philadelphia. They are edited by well known authorities in England, and issued in pocket size, 12 mo. volumes of 300 to 500 pages, well illustrated, and at a low price. The works are not pretentious, but will serve a useful purpose as books of reference on the subjects upon which they treat.

**A TREATISE ON HEMORRHOIDAL DISEASE, ITS HISTORY, NATURE, CAUSES, DIAGNOSIS AND TREATMENT**, by Wm. Bodenhamer, A.M., M.D. New York: Wm. Wood & Co. Toronto: Hart & Co.

We believe this is the only work on the subject of hemorrhoids published; at all events on this side of the Atlantic. This treatise will be found to be a complete encyclopædia on the subject, and will repay a careful perusal. As a work of reference it cannot be excelled.

**HAY FEVER, AND ITS SUCCESSFUL TREATMENT BY SUPERFICIAL ORGANIC ALTERATION OF THE NASAL MUCOUS MEMBRANE**. By Charles E. Sajous, M.D. Illustrated by 13 Wood Engravings. Philadelphia: F. A. Davis, 1217 Filbert Street.

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## Births, Marriages and Deaths.

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On the 11th ult., Dr. J. W. Walden, of Waterloo, aged 47.

On the 20th ult., Dr. Joseph Mothersill, of Stratford, aged 65 years.

On the 28th ult., H. L. Vercoe, M.D., of Toronto, aged 45 years.

On the 20th ult., Fanny Creighton, beloved wife of Dr. L. F. Millar, of Woodhill, aged 28 years.



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## Original Communications.

### STRICTURE OF THE URETHRA TREATED BY CHEMICAL GALVANO-CAUSTIC, OR ELECTROLYSIS.

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(Translated from the Portuguese of *União Médica*.)

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Electrolysis has been employed in the cure of strictures of the urethra, aneurisms, and various tumors. In 1807, Davy tried to destroy a fillet of muscular fibres with a pile of 150 elements, noting in its rapid decomposition alkalies at the negative pole and acids at the positive. Here were established the primary lineaments of the method, which Nelaton called electrolysis, and Iripiet chemical galvano-caustic. After the celebrated experiment of Davy, some time having elapsed, Pravaz, Ciniselli (of Cremona), Broca, Nelaton, Velpeau, and numerous other celebrated surgeons, employed the method to destroy tumors and urethral strictures. Before, however, thinking of the application of galvanism, numerous empirical experiments relating to surgery were made; but the operatorial conditions being ill determined, and the interpretation of the results unsatisfactory, these investigations were abandoned. Between 1841 and 1848, Crussell, of St. Petersburg, wrote several memoirs on the electrolytic treatment of certain engorgements and tumors. These works, in their plurality, are inedited, and are to be found in the archives of the Academy of Science in Paris. After some years of study of the method of cauterization, based on the analytic properties of the electric currents, Crussell renounced the thermo-galvanic method, and engaged in the study of *thermo-galvanic cauterization*. It is certain that this author had a confused view of the grand resources of electro-

lysis, and an extremely vague notion as to the idea of the surgical applications which might comport with this order of phenomena.

Ciniselli is the only one who won the honor and the applause of having brought electrolysis to a perfectly definite method, through having comprehended its mechanism and capabilities, regulating the processes of its construction, and leaving no hesitation as to the nature and extent of the services which it may afford. The surgical value of the method was not completely attained by Ciniselli. It was Tripiet who had the merit of appreciating the advantage of negative chemical galvanism in the treatment of urethral strictures, basing his conclusions on considerations and facts of another order, and impressing them on his followers during his service in the hospital for children, in Paris, where certain scrofulous manifestations had been treated by the application of caustics, the result of which was judged of by the cicatrices produced. Soft and smooth cicatrices were attributed to alkaline applications, and hard and rough ones to acids, or the actual cautery. I set about studying experimentally," says Tripiet, "the influence exerted on the cicatrix by the chemical origin of the wound;" he concluded from his experiments that chemical caustics give two principal sorts of cicatrices; the alkaline give soft cicatrices, which are but little, or not at all, retractile; the acid ones give hard and considerably retractile cicatrices; the negative pole of the pile gives cicatrices identical with those from alkalies; the positive pole gives cicatrices comparable to those from acids, and from the hot iron. Ciniselli precisely described the experimental conditions of a phenomenon, whose mechanism was first understood by him, from a series of facts observed with all the rigor of logic, and he thus became the creator of the method; Tripiet, by assimilating the practical consequences of the facts empirically observed, and conjoining these consequences with preconceptions exclusively original, described the therapeutic indications of the method, with all scientific rigor.

The result of the investigations of Campos Bautista and Palomeque, in an inaugural thesis of 1870, fully confirm the proposition formulated by Mallez and Tripiet, in relating their own experiments. Thus, then, negative electrolysis will be employed to destroy strictures of the urethra, and will furnish a soft, smooth and dilatable cicatrix;

the positive chemical galvanism will be used in the cure of aneurismal tumors and will give an albuminous coagulum. The attempts of Crussell and Wertheimer having failed to realise the idea of causing galvanism to act on urethral strictures, proved unprofitable. Their apparatus was imperfect, for the purpose of dissolving the peri-urethral engorgements, to which they ascribe the producing cause of the urethral contractions. The electrode of Mallez is a staff, terminating in an olive, or a cylinder, and it is covered, excepting at its point, over its whole extent, by a gum-elastic sound. This instrument is introduced by a conductor; its management is difficult. The author had the idea of furnishing it with a conducting sound, but for several reasons he gave it up. Dr. Jardin, his clinical assistant, had an instrument constructed under his own instructions, similar to the urethrotome of Maisonneuve—less the cutting blade—which was substituted by a rhomb of platinum, and had the catheter protected by a sheath of gum-elastic. This instrument is perfect; it acts well, and there is no fear of injuring the wall of the urethra. The author presented it to the Paris Academy of Medicine. In the course of the month of January, 1885, I tried some experiments, in which I employed the two instruments. I took a large piece of the muscles of the loin of an ox, containing a dense aponurosis, which divided the piece into two portions. A tent-canula was introduced perpendicularly, making a trajet which merely gave passage to a canulated catheter of Jardin. I passed the lamina along the sulcus far enough to come into contact with the muscular texture. The positive pole of the pile of Gaiffé was placed on the muscle at a distance of 10 centimeters: the negative pole was placed in communication with the electrode. The circuit was made with the positive electrode. The distance through which the lamina had to pass was 8 centimeters, in reaching the aponeurosis at the centre. At the end of six minutes it appeared at the opposite orifice, having traversed the space without resistance. Now we know that aponeurosis is a hard, fibrous composite of bundles of laminous and elastic fibres, which interlace and form a compressed web, sufficiently resistant, and comparable to the fibrous texture of the urethral stricture. The same experiment was made with the instrument of Mallez, which gave the same result, but not so promptly

as the lamina of platinum. Another tillet of muscular fibres and aponeurotic tissue was encased by the metallic wire of our polypotome electrode, which is a modification of the constrictor of Maisonneuve, establishing the electric current; the primitive (positive) pole was put into communication with the instrument, contrary to the first experiment, and the negative pole with the muscle, thus making the circuit. The experiment lasted 40 minutes; the wire became lost in the muscular texture and the tendinous parts, but desiring to hasten the result, I broke it. In proportion as the wire decomposed the textures, a fume of sour and piquant taste was formed, coincidently with the liberation of the gases; this fume was quite saponaceous at the negative pole. From the dissection of the parts traversed by the electrode the disorganization of the textures was exhibited, and we were satisfied that positive chemical galvanism, by the process employed by us, is an incontestible fact, which can be realised by any physician. We employed this process in the extirpation of an extra-uterine polypus, before we had seen the book of Tripiér—*Electrologia Medica*—which we received a good while afterwards.

Dr. Fort, when acting as a clinicist in Rio de Janiero, relative to failure in an operation by electrolysis, published in the *Gazette des Hopitaux*, of Paris, No. 54, an observation which we here introduce, together with the reply of Dr. Jardin, because they are both very instructive. Dr. Fort says, "since I practised chemical surgery in Brazil, I have operated a considerable number of times on strictures of the urethra. I employ *linear electrolysis*, on a large scale, according to the process of Dr. Jardin. In the present instance I would ask Dr. Jardin whether his instrument might not be modified, with the view of avoiding all possible failures? The lamina of platinum, not cutting, which destroys a point of the stricture, appears to me too small, and I think it might, without inconvenience, be enlarged in its depth to the extent of 3 millimetres. I deem this necessary, considering the thickness of the canal of the urethra and its relations with the corpora cavernosa in the upper part." The following are Dr. Fort's reasons given in demonstration of the utility of a modification of the lamina:

1st. In certain individuals the stricture presents some thickness of pathological texture, connected

with some dilatibility of the strictured point. What happens? It is the fact that the electrode, whose lamina is not sufficiently projected, does not destroy linearly more than a part of the thickness of the pathological texture. After the operation a number 18 sound, of the scale of Charriera, is passed through, but sometime afterwards the old undestroyed tissue contracts anew, and thus is lost the benefit of the electrolysis, which, ordinarily gives place to a soft, neurotractile cicatrix." Dr. Fort has observed several analogous cases, and he says that they are recognised by the reproduction of the stricture, which may be expected in a few months. "Let us then," he writes, "elevate the lamina of the electrode." "The *ecraseur*, combined with the chemico-galvanic cautery—a lacing of metallic (iron) wire, conducted by an isolator," says Tripiet, "forming one electrode of a current whose circuit proceeds to closure in the vicinity—will operate simultaneously by crushing and cauterization. In the ablation of uterine polypi, for example, the *ecraseur* will be the positive electrode, in order to diminish the possibility of hemorrhage; in the ablation of pediculate hemorrhoids, it will be the negative electrode, in order to diminish the retractile tendencies of the cicatrix." That we may not be accused of plagiarism, this point calls for rectification. We have said elsewhere that Nelaton, in 1864, operated in this manner on a naso-pharyngeal polypus, but he availed himself of an apparatus consisting of a canula of guttapercha, containing two needles in its interior, which he implanted in the body of the tumor. The process employed by us is different. Reflecting on the result obtained by the rhomboid lamina of the electrolyser of Jardin, on stricture of the urethra, and considering that decomposition is made rapidly, without pain and without hemorrhage, we entertained the idea of extirpating this polypus by electrolysis. Some physicians, among whom is one of my friends, doubted the result. There stand the words of Tripiet to convince them, once for all, of the reality of the process. Some also have doubted the action of electrolysis in urethral strictures, thinking that instead of decomposition there is divulsion, which in the hands of able surgeons has given excellent results, according to the reply of Dr. Jardin to Dr. Fort, when this surgeon said he had decomposed a stricture of the urethra in 25 seconds! Dr. Jardin affirms that in this short

period of time electrolytic action does not come into existence.

2nd. In certain patients the stricture is short, probably not very thick, and possessing great elasticity. The lamina of platinum of the electrode traverses the stricture from before backwards: afterwards it passes, on withdrawal, in the inverse direction. The patient urinates better for some days, but relapse follows. If, in this case, the lamina were more elevated, a certain degree of tension would result in the strictured ring, and chemical destruction would be produced. Mr. J—— came to consult Dr. Fort in May, 1883, about a short stricture which allowed a number 9 sound to pass. "I treated it" he says "with the linear electrode of Dr. Jardin. During some weeks the patient was better. The symptoms became worse, and the stricture attained such a degree that it did not admit a No. 4 sound during the night of Friday. On the next morning the patient introduced a No. 6 sound. On Sunday morning I passed into his urethra a No. 8 sound, and left it in for an hour. Afterwards a No. 9 sound, during half an hour. I next passed a conductor and the canulated catheter, which fortunately reached the bladder. The lamina of platinum of the instrument of Jardin was applied against the strictured point, and the circuit was made. The operation lasted twenty-five seconds. I employed 18 elements of the pile of Gaiffe, making slight pressure on the ivory button of the electrode. The flow of urine is large enough, and everything leads to belief in the absence of reproduction" (of the stricture).

In our own operations we always avoid making pressure on the ivory button of the electrode in order to procure the decomposition of the pathological texture by the proper action of the chemico-electric current. Afterwards, and always when the lamina has passed rapidly, we take care to delay it at the level of the point of stricture, so that the contraction may be attacked both in front and rear.

#### PART SECOND.

#### CHEMICO-GALVANIC CAUTERIZATION WITHOUT A CONDUCTOR, OR ELECTROLYSIS BY THE PROCESS OF JARDIN.

"Traumatic strictures of the urethra justly pass as incurable," says Dr. Jardin. In reality we must

confess that the means employed, and particularly that of internal urethrotomy, by the process of Maisonneuve, have furnished insufficient results, and but of short duration. Valvular strictures have, almost always, for some time past, been treated by urethrotomy, with the cutting blade (*lamina*). In the first case—traumatic stricture—an operation is practised which gives a result only more than middling, and in the second—valvular stricture—an operation is performed of great gravity, to combat an insignificant lesion. It is from these considerations that we deem it useful to relate the history of a case of traumatic stricture, which we shall first give, and also of a valvular, one which was twice treated by incision, according to the process of *Henrteloup*, and which, having a prompt relapse, yielded completely to chemico-galvanism.

Early in December, 1880, J. D., a child of ten years, fell on his perineum, on the head of an iron bed. His mother observed a bloody discharge from the urethra, which stained his clothing. The history from the moment of the accident up to the day on which we saw him, is as follows: On the first day, urethral hemorrhage, fruitless trials of catheterism, cold compresses to the perineum, a hæmostatic potion. At the end of 20 hours the hemorrhage ceased. During the 8 days following, absence of blood in the urine, micturition rather free, though painful, absence of fever, extensive ecchymosis in the perineum, with infiltration of urine. Urethral hemorrhage, without appreciable cause, on the ninth day, but it was stopped by applications of ice to the perineal region. On the next day the little fellow was brought to the hospital for children, when catheterism was practised with a metallic sound, and then he was taken home. Douches were employed during three months, by advice of the physician. During this time micturition became constantly more difficult; the flow of urine became gradually thready, and finally came only in drops; retention ensued, and urine passed only when engorgement was reached; this condition resulted in diurnal and nocturnal incontinence. It was in this state that the patient was presented to me on the 7th of July, 1883, 18 months, more or less, after the accident, in a state of considerable emaciation. He was constantly wet with urine, and in the urethra there was found, at the level of the bulbo-membranous region, a hard

stricture, resistant and impassable. There was also an elongation of the prepuce with a marked constriction of its margin—a congenital phymosis. Catheterism was tried with filiform sounds during many days, without success in passing the stricture. Several vesical punctures were made in order to remove the great distension. From palpation of the perineum we formed a sufficiently exact notion of a hard and pretty long stricture, situate under the symphysis pubis. We then decided, without giving up the attempts at catheterism, with very fine whalebone sounds, to practise circumcision, which was effected on the 11th of July, 1883. As soon as he recovered from this operation he disappeared for three months. In the beginning of November catheterism was again tried, without success. We then resolved, in the middle of December, to make, in the forward part of the stricture, application of the chemico-galvanic cautery, without the conductor, of which Dr. Mallez made use on the occasion of the first applications made by him with Dr. Tripiet, which had often given excellent results. This operation was practised on the 14th of December, 1883. The patient was subjected to chloroform. The galvanic cautery was introduced into the urethra. One of the extremities was placed in contact with the stricture, and the other with the negative pole of a pile of chloride of zinc, of *Gaiffe*, whilst the positive pole corresponded to the electrode placed on the thigh. A current from 18 elements was kept in action for 15 minutes. The milli-ampere showed 45 degrees. During these 15 minutes of action of the pile, the galvanic cautery penetrated a little into the texture of the stricture, which offered considerable resistance. We therefore took care not to exert much pressure, as it was our desire to modify only the forward part of the stricture so as to render it permeable to sounds. No attempt at catheterism was made after this sitting. The patient returned after six days, and we were able to pass a filiform sound, which was strongly grasped by the stricture. Catheterism was regularly followed up, two or three times a week, and at the end of January, 1884, we passed a number nine of the scale of *Charrière*. The incontinence became modified; the patient passed several hours without involuntary escape of urine, but the night incontinence persisted.

In the first days of February dilatation gave no further result. In presence of the impossibility of

continuing the dilatation, and encouraged by the advantages gained in the first sitting, from galvanocautery, we decided on a second sitting, which took place on the 15th February, 1884. We performed it with our galvanic cantery with the running, not cutting, lamina, and the lamina chosen was the less size, that which, joined to the staff, corresponds to number 13 of the scale of Charriere. The selection of this small lamina was based on the idea which we entertained of the hardness of the stricture, and of its possible great extent. We thought we could, with a small lamina, run through the whole extent of the stricture, as slowly as might be necessary for establishing an eschar at all the points passed through. The sitting lasted twenty-three minutes; twenty elements of the pile of the bi-sulphate of mercury, of Chardin, were employed. The lamina traversed the stricture with sufficient facility, over the distance of a centimeter and a-half. After traversing the stricture, which was accomplished in four minutes, we drew back the sound to the most contracted point, and detained it there for 19 minutes, acting with 20 elements.

I introduce here a parenthesis, in order to reply to Dr. Fort, who, in No. 24 of the *Gazette des Hopitaux* of 8th May, 1884, published a case of stricture which was soon reproduced, and he attributed the failure to the instrument (the electrode) which, as he thought, had a platinum lamina that was not projecting enough. "Let us," says Dr. Fort, "elevate the lamina, and we shall avoid failures." We have only one reply to make to this remark; it is this: We are at a loss to place, at will, in the canulated catheter of our instrument, any one of our seven rhomboid laminas of platinum, the least of which is equal to No. 13 of Charriere, and the others are of succeeding numbers.

Before speaking of the choice of a lamina, we, *en passant*, say that from the beginning of our applications of the chemico-galvanic cautery, we renounced the cutting laminas which we got constructed, as we wished to penetrate the texture of the stricture, and to detain our lamina there so as to produce an eschar with more certainty. Internal urethrotomy had been complicated with electrolysis, and was effected in very bad conditions. We also renounced laminas fixed on the electrodes, an arrangement which might appear advantageous, but which in reality presents two inconveniences of great moment: In the first place it obliges us to

withdraw the whole apparatus from the urethra, when it may be necessary to change the lamina; in the second place, and this is even of greater moment, it does not, in many cases, permit us to recognise the cause of the stopping of the instrument in the canal of the urethra.

But let us return to our selection of the lamina. Notwithstanding the great number we have, we use only the smallest, and avoid, as much as possible, large ones, the elevated, to which Dr. Fort appears to give preference. This decision has arisen from the large number of facts observed in our applications of chemico-galvanic cautery, practised in the canal of the urethra, and from the experiments made by us on living animals as well as on the flesh of these after death. We shall cite merely two capital facts which, alone, will justify our mode of thinking. We know that in our organism, the blood is one of the best conductors of electricity. If, by chance, in chemical galvanism, the platinum lamina, placed in contact with the texture of the stricture, becomes moistened by some drops of blood, the current will be turned away, and the phenomena of electrolysis which should be produced by those of chemico-galvanic cautery, are transferred to a point more or less removed from the stricture. Hence comes failure despite the elevation of the lamina of platina: because when an instrument penetrates, by an opening, into an irritated and congested mucosa, there is every probability of a hemorrhage, however insignificant. On the other hand, it may be believed that with an elevated lamina, the pressure on the texture of the stricture being stronger, the eschar produced will be deeper than that from a less elevated one. This idea is erroneous; because if the lamina be placed on a piece of flesh of an ox, and the circuit of a large electrode be closed in this flesh, it is seen that the extent and depth of the eschar is not proportioned to the pressure used; but merely to the time, and to the number of the elements put in action. From these considerations we think we may draw the conclusion that the failures we recorded in the commencement, and those communicated to us by Dr. Fort, were due to one of the causes we have now cited, and not to the imperfection of the instrument. Dr. Fort, in the observation published in the *Gazette des Hopitaux*, says, that in the second sitting, aided by an elevated lamina, he traversed the stricture in *twenty-five seconds* and with success. It



is possible that such an event happened: but in this case the success was due to a well made divulsion, since galvanic cauterization in 25 seconds is not possible, whilst direct divulsion has furnished fine results in the hands of able surgeons.

Let us now return to our subject. We practised, on the 15th of February, 1884, a sitting of 23 minutes, using twenty elements with the bi-sulphate of mercury. There was not a single drop of blood. The patient rested during ten days. He urinated copiously, and the diurnal incontinence disappeared. There were many nights in which involuntary escape did not occur. It is true that his mother always took care to rouse him at least once every night. On the 27th of February, 1884, we made another dilatation, and we repeated this operation afterwards three times weekly. The texture of the stricture seemed to have lost a little of its hardness, and this permitted us to advance, at the end of a week, to No. 13 of the scale of Charrière. In the course of the month of March both the daily and nightly incontinence ceased. The patient's health improved rapidly, and the dilatation was prolonged until May, when we decided on another sitting, under the chemico-galvanic cautery, in order, in the words of Tripiér, to throw some more negative elements into the texture of the stricture, and consequently to diminish its tendency to retraction.

On the 9th of May, 1884, we had a new sitting of electrolysis, with 20 elements of the bi-sulphate of mercury. The lamina, employed, when joined with the catheter corresponded to No. 17; the stricture was traversed in three minutes; afterwards, having conducted the lamina back to the level of the stricture, it was kept there for 17 minutes. There was complete absence of blood—a condition eminently favorable, even indispensable for securing direct action on the stricture. A number 15 was easily passed on the 19th of May. It is worthy of notice that after each sitting the child was exempt from all febrile reaction. Summing up: Here was a traumatic stricture—that is, one formed of fibrous textures, hard and unyielding—a condition justifying the qualification *incurable* as applied to this class; but after three sittings under electrolysis, I succeeded in passing a No. 15, and the texture of the stricture became so modified that it lost the tendency to early retraction.

Let us now see some notes on organised and vulvular strictures which yielded to electrolysis

after they had resisted the old processes. These observations are necessary in order to combat the erroneous and captious opinion of those who are disposed to regard the method as bad, and inferior to the old system. The words and facts of Drs. Jardin and Mallez, contained in these notes, are very convincing, and they enable the impartial reader to judge, and to weigh the different opinions with all rigor and critical exactitude. But first let us discuss the value of the method and contrast it with internal urethrotomy.

Colonel F— presented himself to Dr. Mallez in March, 1881. He experienced extreme difficulty in the act of micturition, though the volume of the flow was not much diminished. He said this was the third time that such trouble had fallen to him. The first was in 1879, when he found extreme difficulty in voiding urine, and felt a sort of a point of stoppage in the canal, because of which he applied to Dr. Henrteloup, who diagnosed a stricture, and had recourse to his method of excision. For some months there was improvement, but hardly had a year elapsed when the first symptoms reappeared. Dr. Henrteloup made a second excision, in 1880, and the difficulty in urinating disappeared, but the act was always somewhat painful. In a few months the difficulty reappeared, and gradually became greater. In the first months of 1881, the patient often used a small sound, in order to facilitate the flow of urine. It was at this time that he consulted Dr. Mallez, who diagnosed a valvular stricture, and decided on practising chemico-galvanic cauterization. The application took place in April, 1881. It lasted 15 minutes; the pile used was composed of elements of the chloride of zinc. Dr. Mallez made use of a galvanic cautery formed as a metallic olive, conducted by a staff which also was metallic, and sheathed in an isolating substance. The conductor was a long fine sound. The olive, having reached the stricture, passed through the valve in a short time, but it was again brought back into contact with it during some time, which was necessary to produce the desired eschar. There was no febrile access, and on the following day the Colonel returned to his usual mode of life. From the first day micturition was effected very well, and during three years nothing extraordinary occurred, as concerned the urethra, excepting in April, 1884, when a diminution in the volume of the discharge, that attracted the patient's attention,

appeared. Considering the remarkable improvement which the patient had obtained, Dr. Mallez, when again consulted, advised the same method, and in the course of April he had a sitting of electrolysis lasting 14 minutes. Sixteen elements of a pile of bi-sulphate of mercury were brought into action. The olive of the galvanic cautery passed the stricture in a minute and a half, and being then drawn back, it was delayed for 14 minutes. From this day the flow of urine resumed its normal force and volume, and ten days afterwards Dr. Mallez found that the canal admitted, without difficulty, a number 18.

These two clinical histories, from their importance, merit particularly the attention of physicians: the first, especially from being that of a case of traumatic stricture of the urethra, as it presents, in reality, an example of cure (obtained after the employment of three sittings) of a case that had before resisted all the means employed and was regarded as incurable. In these two clinical histories it is seen that electrolysis may perfectly supplant internal urethrotomy, in cases of complete obliteration of the canal of the urethra, or in impassable strictures, by means of the galvanic cautery, without the conductor of Mallez. Dr. Jardin followed the process of his master in giving entrance by means of the conducting sound of his instrument, which he subsequently applied, thus effecting the cure of an affection considered incurable, by means of the old processes. In such cases by having recourse to electrolysis, seeing that its employment cannot result in any accident, we avoid unnecessary cutting of the urethra. This advantage is owing to the employment of the instrument of Mallez. We have also seen that though employing, at the commencement of his experiments, the galvanic cautery without a conductor, he mentions the possibility of the application of the conducting sound, which he afterwards omits, giving his reasons for so doing; but we again find him using electrolysis with a conductor, as we have seen in the case of the Colonel. This shows us that practice is a great book of study, from which we may imbibe in large drafts, aided by the light of logic and of critical judgment, all the notions complementary to any idea whatever.

We may now compare the observation of Verneuil, published in No. 48 of the *Gazette des Hôpitaux*, 1884, relative to the accidents consecu-

tive to external urethrotomy, with that of Jardin, which we have before given. "Three weeks ago, more or less," writes Verneuil, "I made repeated attempts to penetrate into the canal of the urethra of one of my patients who had an impassible stricture. In consequence of this there was a slight urethritis with some febrile disturbance and some glandular swellings. We let his urethra alone, and after some days, by means of emollients and resolvents, all these symptoms ceased, satisfying us that in this relation all was ended. Now, if on this side it was necessary to wait a certain time in order to avoid any relapse, on the other side interference became urgent, and external urethrotomy must be practised. Four days after we proceeded with the operation, without a conductor. The perineum was found in a good state; there was no fistula: I penetrated into the urethra, and then, introducing a catheter, I opened the canal with the thermo-cautery in front of the stricture; I then tried to reach the bladder. During half an hour I made various attempts in vain, and I was forced to stop. Moreover, there was no inconvenience in this, as patients usually urinate on the next day through the perineum, and in a few weeks, by means of this fistula, a sound is conducted into the bladder and the operation is completed in another sitting. I had believed that my interference would not be followed by accidents: unfortunately I had not taken into account the wound; the introduction, several times, of the sound, provoked reproduction of the urethritis; there was an auto-inoculation; the lymphatics became again inflamed; the glands were engorged, a double inguinal adenitis resulted, and the lymphangitis extended to the scrotum. How was the auto-inoculation produced? It was due to the little microscopic erosions, which favor the inoculation all the more the less they are. Some are of the size of vaccine pricks, and their success is in proportion to the insignificance of the injury. The wound in the perineum, made by the instruments, is not the cause of this lymphangitis; the cut is perfectly healthy, whilst at the same time the erosions of the passage which appear only accessory, are, on the contrary, the true cause. Whatever may be the state of my patient, it occurs to me he will not succumb; but, in the event of death, it ought to be imputed to some insignificant erosion of the canal, caused by the introduction of the catheter. It is hence to be inferred, that when

you find yourselves confronting two coincident injuries, it is well to look equally to both, and, besides, to conform to this precept: *do not operate too soon*. Here, it must be confessed, the intervention was much too soon, that is, before the canal had returned to its normal state. It is one of the errors frequently fallen into in foreign clinics, in which the patient is operated on the day after his entrance. For this reason I always forbid my pupils—except in cases of urgency—to explore the urethra on the patient's entrance. Summing up then: 1st. It is imperative not to injure inflamed textures, unless under absolute urgency; 2nd. By proceeding hastily a door is opened to auto-inoculation; 3rd. This may be the result of a microscopic wound; 4th. Adjuvant operations have an especial gravity, which may be followed by accidents in practising a minor operation."

There is not a doubt that the preceding observations have been traced by the hand of a master, one of the most celebrated surgeons of Paris, and that the accidents following his surgical intervention were due solely to the old system. He had in hand an impassable stricture; there was necessity to interfere, and Verneuil performed the operation; he effected external urethrotomy, and thus gave place to all that cortege of accidents, which placed the patient in a deplorable state, worse in fact than that in which he was before his entrance into the hospital. Mallez, with his galvanic cautery, without a conductor, has, by electrolysis, succeeded in reaching the bladder without cutting the urethra, thus avoiding a painful operation, which is full of peril and accidents, as we have seen in the case of Verneuil. The celebrated electro-therapeutist proposes the substitution of the process, and he abandons external urethrotomy, in presence of the excellent results he has secured in his practice on the urinary passages. As to the advice of Verneuil, we daily infringe it, in exploring and operating on the patients who come to consult us, and we have not had any complaint as to our mode of proceeding, since no accident has accompanied or followed the sittings of electrolysis, which are usually, at the least, unsucceeded by accesses of urethral fever.

In the present state of science two theories are offered in explanation of the cause of urethral fever. The first is that of inoculation; Maisonneuve was the first who, in these cases, spoke of auto-inocula-

tion, and of the accession of consecutive septicæmic fever. The second theory is that of nephritis. "When one is young," says Verneuil, "he may be absolute; when he grows old, he turns eclectic." Maisonneuve was the initiator of whatever has been done as to inoculation from septic products in wounds; and although his memoir saw the light only in 1862, he had for a long time before taught the same in his course. In the meantime, as I was a disciple of Maisonneuve, I found myself tied to the theory of nephritis; I profess the same idea to-day, but with this difference—that I accept both theories, that is, renal congestion in chronic nephritis, and the wound with septicæmic auto-inoculation. In another case, more or less identical, Verneuil shows his embarrassment and his inability to relieve a stricture periodically impassable, if we may be permitted to say so. "Now," says he, "after several attempts made in the meantime with the greatest care, without using any violence on the urethra, the patient was attacked by a very violent access of fever—urethral fever, according to all the probabilities; at the same time the right testicle was enlarged and became the seat of an orchitis consecutive to catheterism. A surgical nephritis, pretty notable, was realised, a parenchymatous nephritis, which gave place to intense albuminuria. Here was an exploration of the urethra resulting in the accidents of albuminous nephritis and an anomalous orchitis.

From our first urethral explorations we have employed antiseptic catheterism, being convinced that Listerism is a potent enemy of the great microbial family—the cradle of the innumerable accidents that complicate the majority of surgical interventions. This great discovery, which had its dawn with Pasteur, in France, broke forth in grandeur in Albion with Lister, the great propagator of the method which has taken his name. To annihilate the microbes with antiseptics is to close the door against the assaults of these parasites, whose destructions are always incalculable when their presence becomes permanent. The action of antiseptics is to-day admitted by all those who have been enlightened by the sun of discoveries, which now floods the intellectual universe with its fecundating beams. "Antiseptic therapeutics," says Bouchard, "is the therapeutics of the future." Listerism is even yet disdained by some celebrated surgeons, who conservatively stick to the old doctrines

despite the cheats daily suffered by them. Antiseptic catheterism, antiseptic surgery, prevents the series of accidents which are met with by those who do not employ it. Had Verneuil vigorously followed Listerism, as it has been taught by its author, it is certain that he would have been sheltered from those surgical complications which many times embarrass the operator who despises it.

The employment of carbolised vaseline at 2 per cent., with which the surgeon ought to lubricate his hands, as well as the instruments that have to penetrate into the urethra or the bladder, is a very rational proceeding, and it brings all the desirable advantages. By adopting this means, which is easy of execution, and is available by every one, contrary to that which Verneuil advises, we practise catheterism as soon as the patient is presented to us, and we continue the operation when ever it is possible to introduce the conductor of the instrument of Jardin, which we also disinfect. We well understand the necessity of disinfecting an instrument that is bathed, in almost its entire extent, by decomposed urine, which is often infectious. To penetrate into the urethra and bladder of a patient, wherein slight excoriations are often produced, without taking the advised precautions, is, so to say, to hasten the evil work of the microbes.

Another discovery not less important to the surgery of the urinary passages has recently been made. The hydro-chlorate of cocaine, an alkaloid from the coca of Peru, which at first was destined to ocular surgery, as an anæsthetic, producing insensibility of the sclerotic, has come in to afford great assistance in the operations of minor surgery, in which the patient, in many instances, refuses to undergo chloroform in order to escape pain. Some English surgeons have employed the hydro-chlorate of cocaine, in surgical processes on the pharynx and the larynx, the nasal fossæ and the rectum, in ablation of the neck of the uterus (the 10 per cent. solution), and in all the cases local anæsthesia has been thus obtained, so that we advise it in operations on the urethra, applying it in instillations by means of a sound of Guyon. Unfortunately its high price must prevent extensive trial of its virtues. Some houses in London have lowered the price to one and sixpence for 5 centigrams (say 36 cents for  $\frac{3}{4}$  of a grain) with the view of encouraging its employment. We see then that this discovery

may be turned to profit in bloody surgery of the urinary passages, in external and internal urethrotomy, but not in chemical galvanism, which is not painful, and constitutes in itself, at the negative pole, an anæsthetic, as Tripier affirms.

## NOTES OF AN ANOMALOUS FORM OF CHOREA.

BY DAVID INGLIS, M.D., DETROIT, MICH.,

Prof. of Mental and Nervous Diseases, Detroit Med. Coll.

The following case being an unusual one and illustrating some points in the natural history of chorea, is deemed worthy of report. Heinrich K., æt. 66 years, farmer, has a history of chorea lasting now nearly forty years. In 1846 the patient (at that time a shepherd) was constantly exposed during an unusually wet summer and at night frequently slept on wet straw in his shepherd's hut. The succeeding winter was intensely cold and he then began to show the first symptoms of the disease, which was a jerking of the right leg. The disorder gradually, but within a few months, invaded other parts of the voluntary muscular apparatus until, except the face, few if any groups of muscles have been spared. This jerking consists in sudden and violent involuntary muscular contraction, as, for example, he is obliged at times to leave the table when at meals as the jerking of the arm is so pronounced as to prevent him from carrying food to his mouth. By walking about for a few minutes he is usually able to resume his interrupted meal. Again, while sitting quietly engaged in conversation, the muscles of expiration will occasionally contract with violence, so as to cause an explosive expiration. When the patient rises and starts to walk, after taking one or two short steps, he will suddenly stagger violently as if about to fall and in apparent effort to regain his balance will stamp upon the floor with great force and erratic movement: having regained his balance, will take a few properly co-ordinated steps and again stagger. This peculiarity of gait differs from the gait of cerebellar disease in that it is not caused nor accompanied by any sensation of dizziness, occurs on either side and is not in any sense a rotary motion. It is also a curious fact that, although the impression of a bystander is that he must certainly fall, he has never, in all the forty years, done so.

Another phenomenon and one which renders the case unusually interesting, is, that when the patient has fairly gotten started he can walk with very little interruption.

I think it was Sidney Smith who remarked about walking, that if a pedestrian sets out to accomplish a given distance, say five miles, he can do it with ease and with little or no weariness; but if one sets out over an unknown road for a place whose exact distance is unknown but supposed to be a couple of miles, if it turn out to be five miles the traveller will be weary. In other words, the traveller in the first case is "wound up" to run five miles and that being done the rest of the walk becomes automatic, while in the latter case there is required a constant exercise of volition. So, in the case of our patient, the first setting out requires the control of the cerebral cortical centres, but when he has fairly got a-going and walking becomes automatic, the lower co-ordinating centres taking control, the patient does well enough. Not only is this the case with walking simply, but the patient will stagger out from his home to his fields and taking his hoe will do a steady forenoon's hoeing with only an occasional interruption. Hoeing, to a market gardener, has become automatic. The patient finds that the choreic movements are worse when making any voluntary movement after having been at rest, as, for instance, on first rising in the morning or when about to resume work after meals. He is, so to speak, being wound up. These movements however, while affecting only the voluntary muscular apparatus, are not confined to such times as the patient is making voluntary movements, but occur when he is at rest and quite frequently during sleep, so that at times the patient will be awakened by the violence of the movements which are not connected with conscious dreaming. The movements, too, are worse on the approach of and during storms, probably during the time of low barometer. They also become worse when the patient has been exhausted by much work. Further negative points as regards present condition are, that the patient is a ruddy hale old man, whose nutrition and general functions are carried on very well. Muscular strength good; mental faculties seem sound; heart sounds normal; sensation and reflexes normal; no paralysis, paresis, contractions or atrophy.

As regards past history, it may be noted that

there is no history of defined rheumatism, nor of syphilis, nor has he ever had any paralysis. There have been in the past certain sensory symptoms, which have not been constant; these were, a sensation of painful cramp coincidently with the jerking, and a feeling "as if many worms, two inches long, were wriggling in the flesh," which preceded the jerking. Some ten years ago, had quite severe pains in the dorsal vertebra, which lasted about six months; during part of that time the movements affected the muscles, causing constant alternating rotation of the head. At no time has he been delirious, but at various times during these forty years has been very dizzy, more in former years than of late. The dizziness, when it occurred, was not a passing sensation connected with the stagger, but a continuous sensation lasting many hours.

The case illustrates several points. 1st. The occurrence of chorea in the aged. 2nd. The fact that neither the general nutrition nor the mental condition are necessarily seriously impaired. 3rd. The economy of nervous force, by which movements which are habitual become to a certain extent controlled by lower co-ordinating centres.

### CALCULUS OF THE FEMALE BLADDER REMOVED BY LITHOTRITY.

BY J. R. HAMILTON, M.D., ATTWOOD, ONT.

In the early part of January, 1885, I was called to see Mrs. A—, aged 59 years, a resident of the township of Elma. I found her complaining of violent pain in her back and sides, which was aggravated by every movement that she made. Inasmuch as I had attended her for one or two attacks of nephritic colic during 1884, I made some enquiries as to the state of the bladder, when she told me that she had on that day passed some blood in the urine, which alarmed her, and was one of the reasons why I was called in. I suspected stone but as I did not have a proper sound along with me I waited until the next day to determine the fact, giving her an opiate in the meantime. On introducing the sound next day I discovered a pretty solid stone without any difficulty. It was situated on the right side of the bladder, and apparently fixed, as I found it there at several subsequent soundings. As the patient was very sen-

sitive and stoutly objected to any operative interference at first, I merely prescribed a mixture of acetate of potash and hyosciamus, and advised her to drink barley water frequently. After a time she allowed me to try dilatation of the urethra, which I had preceded by injections of warm water about twice a day. After some futile attempts at crushing with dressing, and polypus forceps, and as the hopes of the patient were not realized in the expulsion of the stone; although position, the filling of the bladder with tepid water, etc., had all been tried, with no other effect than the apparent dislodgement of the stone from its first position, as I now found it in the bas-fond, and could detect no stone in any other part of the bladder I then, with the final consent of the patient, resolved to try lithotripsy before resorting to lithotomy, as my patient was a very stout and plethoric subject with an apoplectic family history. On the 7th of May, after injecting nearly a pint of warm water into the bladder, I first heated and oiled a very large sound, nearly as large and of the same curve as my lithotrite, and after locating the stone, had not much difficulty in grasping it with the lithotrite and found that the diameter was one inch and a quarter by the graduated scale. On putting on pressure by turning the screw, I found that the stone appeared to shoot out of the blades, and as the patient was nervous I did not make any further attempt to catch it then, and merely washed out the bladder with some more warm water, after which I found a few fragments of stone and some sand in the urine. After this was passed I injected 6 or 8 oz. of linseed oil, and ordered the patient to remain quiet until I should have another sitting. At the end of three days I had another sitting, when the patient assured me that she could turn in bed better and much easier after the former imperfect crushing, due, perhaps, to the rough edges of the stone being somewhat ground off. I followed the same routine as before, but this time was more successful as I crushed it through with a great deal of difficulty, and after the washing found several larger pieces and more sand. I followed these sittings at various intervals according to the state of patient, until I had operated 14 times in all, when on the 3rd of June I had the satisfaction of crushing the last fragment, which was most difficult to catch. After this I had the bladder washed out once a day for a few weeks with tepid water, and some linseed or sweet oil in-

jected occasionally. My patient was, in a few days after the last crushing, able to resume her household duties, and she says she has not felt as well for years, and is taking no medicine now only a dose of bicarbonate of potash in a bitter infusion once a day.

In regard to this stone which I have no doubt had been a long time in forming, the general symptoms had no doubt been overlooked, as a case of stone in the female bladder is so rare that few medical men look for or expect it, and surgical literature gives us next to nothing on its treatment. Even Poulet in his admirable work on foreign bodies in the female bladder scarcely says anything of stone, only as a casual formation around other foreign bodies. This stone had no foreign body for a nucleus that I could detect and was a triple phosphate throughout, although somewhat harder than a phosphate should be in the centre.

In reference to crushing in general. Civiale, one of the first writers on lithotripsy, and one who had great success, says: "it is a most important precept to make the sittings very short and to operate *very slowly and gently*." I followed this precept religiously in this case, which, although requiring a great deal of time and patience, terminated most satisfactorily. Now as to the use of the crusher, I used Thompson's lithotrite, made by Mr. Stevens, which is much smaller in calibre than the lithotrites in use some years ago, and is in my opinion a model instrument. Nearly every author has his own method of handling a lithotrite. Gross advised a wriggling motion of the wrist, and some advise you to get the female blade under the stone, etc. I found that all these movements generally cause the stone to float out of the reach of the lithotrite, causing another search with the sound, and on this occasion I used a lead sound that I could bend to get the stone out of any cul-de-sac into which it might stray, which I found very convenient. I found after a few crushings that the easiest and safest way to catch the stone was to place the point of the lithotrite on it after getting it into the centre of the bladder with the sound, and then holding the lithotrite firmly with the left hand, left elbow supported, in order to prevent the lithotrite (which is much heavier than a sound) from gliding past the stone, reserving your right hand, of course, for the manipulation of the screw. After having once grasped the stone it is very easy to turn it upwards,

or any way, before putting on pressure, to ensure yourself that you have no mucous membrane, which is not often caught, I imagine, when you get the stone in the proper position first and have enough water in the bladder to keep the coats slightly distended. I don't think I ever caught the mucous membrane in this case of Mrs. A.'s, and I never saw *one drop of blood* in the urine after any of the sittings. I don't know what the result would have been had I used anæsthetics, but I never used them during the course of lithotrity and my patient had very few opiates or in fact medicine of any kind. She had, however, used, and still uses demulcent drinks.

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### Correspondence.

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#### THE NEW BRUNSWICK MEDICAL ACT.

To the Editor of the CANADA LANCET.

SIR,—The New Brunswick Medical Act, passed March 25th, 1881, provides that all physicians shall register their names in the Medical Register of the Province and receive a certificate of such registration before being entitled to practice; it also provides that the names of all registered practitioners shall be annually published in the *Royal Gazette*. The Act provides two penal clauses, viz: any person found practicing medicine, surgery, or midwifery in the Province without having registered is subject to a penalty of forfeiting \$20 per day for every day of practice; and any person who claims falsely to have registered is subject to a penalty of \$200. With the exception of the last clause of the Act, which provides that none of its provisions shall extend or be applied to clairvoyant physicians and midwives, the profession and people appear to be protected, but this is far from the truth of the matter. Every registered practitioner should have protection for the following reasons: first, because he is required to expend a large amount of capital and time to qualify him for registration; second, he is required to pay a fee of \$6 for his certificate of registration; and third, under amendments passed to the Act, he is required to pay an annual tax to the Medical Council, or suffer his name to be erased from the Medical Register of the Province. The amendments do not seem to work satisfactorily, as the Medical Register of 1884 contained 200 names, while that for 1885

only contains 120. We have sought a reason for this delinquency, and the answer was, "we do not wish to contribute towards the benefit of the few, or pay taxes for which we receive no equivalent." Now, granting that the practitioner fully complies with the Act and its amendments, what are his privileges? He is legally qualified to practice his profession in the Province and to recover fees for his services; nothing more, nothing less. A quack may practice under his notice from day to day and exact exorbitant fees, while the physician is powerless to prosecute him—the power of prosecuting offenders being entirely vested in the Medical Council, the members of which reside in the cities far from the operations of quackery—and hence the result. "Dr." Sewell travels over the country visiting the sick, and prescribing "Morning Glory," and abuses his patients if they do not purchase his remedies; "Dr." Golden, prescribes cajuput oil locally for congenital cataract and receives a fee of \$18; another "Dr." professes to heal the sick with roots and herbs, and dupes his patients with a mixture of chloroform, ether and aromatics, inflicting physical injury on some, while others are hastened to the grave. Language fails us in depicting the enormity of this imposition upon our profession and people. As members of the medical profession let us assert our rights, and urge our legislature to amend the Act, empowering every citizen of our Province with authority to prosecute offenders, and otherwise vindicate our Medical Act.

PRO BONO PUBLICO.

N. B., Aug. 8, 1885.

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To the Editor of the CANADA LANCET.

SIR,—My attention was called to a letter in the February number of the LANCET over the signature of "A Resident Physician," Cornwallis, N. S. The article does not affect the writer personally, but I think it should not be passed over in silence by the profession in Cornwallis. Before rushing into print, it might have been well for a "Resident Physician" to ponder the old adage that "those who live in glass houses should not throw stones."

Only a few days ago I heard a brother M. D. charge your correspondent with the same breach of professional etiquette with which he charges Dr. B. M.D. seemed to be filled with quite as much righteous indignation, but I have not yet



seen it in print. Admitting the charges to be true, and overlooking the questionable taste of preferring them under a *nom de plume*, there is still a grave fault in "A Resident Physician's" letter. He has no right to drag Dr. B.'s "helpmeet" before the public. It is neither manly nor consistent with that *charity* which beareth all things. Let us not lose sight of our manhood and the dignity of our noble profession in our individual differences.

There is another subject which may interest your correspondent. He alludes to "professional advertising," and I would most respectfully refer him to a "card" in our local paper, in which Dr. — claims among other things, to have made himself familiar with the methods of examination and treatment of eminent specialists in the various branches of medicine and surgery, and being supplied with the latest improved instruments for examinations and operations in disease, both of medicine and surgery, is prepared to give satisfactory counsel and treatment to all. Special attention given to diseases of the head, throat, and chest." Surely such a "card" is not in keeping with the ethics of the regular profession. It might do for Warner's Safe Cure, but I do not believe that sort of thing was learned from those "eminent specialists whose methods," etc.

ANOTHER RESIDENT PHYSICIAN.

Kings Co., N.S.

To the Editor of the CANADA LANCET.

SIR,—On page 373, LANCET for August, you say that in Ontario "no one can publicly practice who has not been found duly qualified after strict examination," and "that it is the duty of every one of us to support our representatives in the performance of their duties by a cheerful compliance with the reasonable demands made upon us."

Each of four neighboring villages to that in which I am located has a person practising within its borders who is not registered. Such being the case it cannot be surprising if some of the "duly qualified" find it difficult to exhibit that cheerfulness (which you say they ought) in complying with the demands annually made on them for fees. Having myself paid between \$70 and \$80 for examination fees and annual dues, I would like to know what are the "privileges and immunities" which I, and others similarly situated, enjoy, for which "the medical men of any State in the Union

would only be too glad to tax themselves to ten times the amount asked of us."

The proceedings of a notorious quack, who, for months made the two eastern Counties in Ontario the seat of his operations, lead me to doubt the correctness of another statement on the same page, viz: "that the people at large have much to be thankful for." They may congratulate themselves that they are not taxed to support the medical council, but that the law, as administered in these counties, affords them any protection from adventurers, is not a fact.

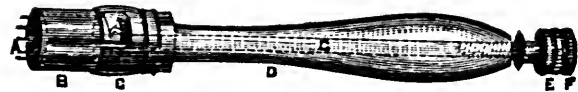
GLENGARRY.

Aug. 10, 1885.

## Selected Articles.

### THE PERCUSSO-PUNCTATOR.

The subjoined engraving gives an accurate idea of the construction and mechanism of a newly contrived instrument for the treatment of rheumatic and other affections, as practically useful in its effects as simple in its construction. The inventor, Mr. Brindley James, penetrated by the result of considerable experience of the high efficacy of acupuncture in the treatment of rheumatism, lumbago, and obstinately persisting neuralgic affections, has succeeded in facilitating its application by this ingenious contrivance.



The puncturing needles A, can be protruded or withdrawn at will, by means of a screw E at the further end of the ivory handle D (which constitutes the body of the instrument), and by a connecting-rod G running through the centre of the latter. An electro-plated cap B contains the needles, and is connected with D by another electro-plated cap C, being attached thereto by a bayonet-lock. A further screw F allows of the connection of the needles (through the rod G) with an electric battery, should the case require it. Mr. James is indebted to the practical co-operation of Messrs. Down Brothers, the eminent surgical instrument-makers of St. Thomas's Street, and the sole makers of the percusso-punctator, for giving practical application to the instrument of his invention, the therapeutic utility of which will soon be universally acknowledged. It is the intention of the inventor to read a paper in the Surgical Section at the forthcoming annual meeting of the Association, illustrating the successful use of this instrument in a large number of cases.—*Brit. Med. Journal.*

CHLOROFORM *v.* ETHER.

SIR,—I confess to a certain feeling of disappointment that my letter on this subject, which appeared in your journal of March 7th, has not produced more expressions of opinion than it has. In THE LANCET only two have appeared, but I have had sent me from the States a reprint of an article in the *Boston Medical and Surgical Journal* of April 13th, 1882, entitled "Homicides by Chloroform," which in its condemnation of this drug goes further than Messrs. Braine and Buxton. Mr. Braine, after quoting my contention "that in the production of complete anæsthesia there is little or no difference (in danger to life) between chloroform and ether, whilst in the after-effects, especially as regards vomiting, nausea, and depression of spirits, chloroform is much superior to ether," and saying that this is exactly contrary to what he has been endeavouring for years to demonstrate, begs to point out to me that whilst ether is a cardiac stimulant, chloroform, on the other hand, is a depressor of the heart's action; that the former never kills by stopping the heart, whilst, on the contrary, the principal cause of death in fatal chloroform cases is the sudden cessation of the heart's action.

Now, is not this too bad? I write a letter in which it is manifest that I take for granted that chloroform kills by depressing the heart's action, and show how this can be remedied, and then am addressed in the *du haut en bas* fashion of "May I point out," &c. I may say further that when I first began giving chloroform, now some twenty-four years ago, I unconsciously came to the conclusion that the heart is the organ on which it tells first, for I found myself always keeping one hand on the pulse whilst giving chloroform with the other, long before I had formulated the opinion in so many words. Next, he acknowledges that dangerous symptoms occasionally arise during the administration of ether: but when these do occur the respiratory organs are affected, and there is plenty of time for the proper application of remedies, these symptoms being rarely followed by death. Surely this is begging the whole question, to elucidate which my letter was written. Are these symptoms rarely followed by death? Let us see. Mr. Braine asks me to consult the statistics of fatal cases, in which I shall find that the proportion of deaths under the administration of chloroform is about 1 in 4500, whilst that under ether is only 1 in 20,000! Where are these statistics? I challenge them at once as false and absurd. I have seen, I believe, at least 10,000 cases of chloroform administration with only one death, and that was a woman who, as we found afterwards, had been drinking heavily for a fortnight. But I have got some statistics, com-

piled for the Registrar-General, who has kindly furnished me with them. I asked for a return of the deaths from the various anæsthetics for the past ten years, but was informed that they could not be given separately; however, a return of the deaths from chloroform and ether (1874-83), in which probably are included those from other anæsthetics in England and Wales, was sent.

Before giving this, let us consider how stand matters bearing on these statistics. First of all, population has increased, but not in so great a degree as to affect materially the comparatively small number of deaths from these drugs. Secondly, there are many operations done now, or done in greater number than were done formerly; but, on the other hand, there are many operations done now without anæsthesia which formerly were done nearly always with it—such as for cataract, &c. I speak of the days before the introduction of cocaine, and without any reference to it whatever. Thirdly, I believe that there is more care bestowed upon the administration of anæsthetics than formerly; and, fourthly, if what the advocates of ether say is true, there is much greater safety in this drug.

From the first three of these considerations we may fairly draw the conclusion that we ought to expect only a slight increase of deaths owing to the increase of population, the other causes balancing each other, but when we add the fourth, we ought to find a great decrease indeed. Mr. Braine says ether is 4444 times as safe as chloroform! Now what are the facts? In 1882, when ether was much used, the deaths of men from chloroform and ether were more than twice as great as in 1874, when ether was scarcely used at all. In women in 1882 there were exactly 75 per cent. more deaths than in 1874. In the second half of the decade, in both sexes, the numbers are 150, as against 104 in the first half.

Ought not these facts to make us pause before we assume that there is the much vaunted safety in ether? Is it not the fact that all anæsthetics universally used are equally fatal, for you cannot abolish all the outward manifestations of life, save those of respiration and circulation, without coming perilously near to the extinction of these. By "equally fatal," I mean this: that if one anæsthetic were used exclusively for all cases through a certain period of time, and another anæsthetic were used exclusively for all cases through another like period of time, the rate of mortality would be the same in each.

I am told by a friend on whom I can rely implicitly that in a ten years' connexion with a large hospital there have been two deaths from anæsthetics, of which one was from chloroform and one from ether. I believe that during the past year, in the United Kingdom the deaths from chloroform and ether have been about equal.

So far I have confined myself to Mr. Braine's let-

ter, inasmuch as the "safety" point is the principal one. As to the other letter, as Mr. Buxton agrees with Mr. Braine, I need not enter further into this point, nor need I dilate much on the sequelæ point, as Mr. Buxton agrees with me in considering that the after-effects of ether are far worse than those of chloroform. I think few doubt this. When the ether wave came from the West I made an experiment on myself, and in consequence obtained an accurate idea of what I should think must be the prodromata of suicide. Later, when I tried the drug on patients, I found that whilst the symptoms preliminary to complete anesthesia were no less terrifying than those of chloroform, the symptoms succeeding were far worse and more prolonged. One old gentleman on whom I operated for cataract had a profound melancholy for several months, which he attributed to ether; and I was repeatedly asked by the matron of St. Paul's Eye and Ear Hospital not to give ether, as the patients were so much more sick and ill, and longer in recovery.

Since writing the above I have received from the Registrar-General a return of the deaths from chloroform and ether—practically of chloroform alone—for the ten years 1864-1873. The numbers are: males 106, females 24, total 130. The lowest year was 1866, with four males to one female; the highest year was 1872, with 19 males to 4 females.

The following is the copy of the Report furnished me by the Registrar-General:

ENGLAND AND WALES.

*"Deaths from Chloroform and from Ether registered in England and Wales in each of the years 1874 to 1883.*

Year.	Males.	Females.	Persons.
1874	13	6	19
1875	16	5	21
1876	20	6	26
1877	12	7	19
1878	13	6	19
1879	14	9	23
1880	17	9	26
1881	24	7	31
1882	27	10	37
1883	24	9	33

Total in the 10 years } 180    74    254"

—Dr. Walker in *Lancet*.

FALSE DOCTRINES IN THE TREATMENT OF FRACTURES.

A paper on this subject was read by Dr. John B. Roberts, in the course of which he said: The great point in the treatment of fractures is, not the kind of dressing that is used, but simply the keep-

ing of the parts at rest. Very little ensheathing callus is formed if the parts are held in coaptation. This is proved by post-mortem examinations. Where the fracture involves the joint, it is important that careful passive motion be commenced at as early a period as possible. Where the joint is not involved, there is no need of passive motion, and hence should not be commenced sooner than the fifth week. Passive motion should never be made while acute arthritis is in progress. Again, splints are frequently worn too long. In simple fractures of the fibula, one week of confinement is all that is necessary. In compound or otherwise serious fractures, a much longer period is required. Another erroneous view is that which opposes the conversion of simple fractures of the cranium into compound, where the case is obscure and an accurate examination can not otherwise be made. The danger of the wound is rendered little, if at all, more serious, and a definite diagnosis can be made. Another error is in the treatment of fractures of the nasal bones by the application of splints or adhesive strips. The proper method of holding the fragments in apposition is by transfixion with pins. Another error in this connection is the placing of canulæ in the nasal cavities to aid in holding the fragments in position.

The important factor in the treatment of fractures of the clavicle is to apply such a dressing to the sternal end of the bone as shall prevent it from sliding forward, as it would do from the weight of the upper extremity. This is to be accomplished by extending the angle of the scapula, and not by the wearing of an axillary pad, which can not succeed in holding the bone in position, unless the pad be so large as to render its use unadvisable. He also claimed that the use of the angular splint for fractures of the neck of the humerus is an error. In fractures about the middle of the forearm, interosseous pads are seldom required if the fragments are put into accurate apposition, and the arm carried in the prone position.

Another error is the use of the straight splint in fractures of the lower third of the radius. The straight splint will do very well for the external surface of the arm, but not for the internal. In most cases the fracture of metacarpal bones can best be overcome by placing adhesive strips over the part attached to the fingers, and to a splint placed under the hand, and, if desired, projecting a little beyond the ends of the fingers.

Finally, it is an error to rely upon measurements of the lower extremities for the estimate of the result obtained from our treatment of fractures. It is surprising that, although the fact that the extremities differ greatly in length has been repeatedly brought to the attention of the profession, it is an almost universal custom for surgeons to measure their broken limbs. Very often, too, where there is no natural difference, there is an apparent one

from the position of the pelvis when the measurement is taken.

Dr. W. F. Peck, of Iowa, stated that, with reference to fractures of the condyles of the humerus, he had for fifteen years taught the importance of using no splints except for support.

Dr. Mudd, of St. Louis, remarked that the great point to be desired is the limitation of inflammatory action about the seat of fracture. Control that, and you control the amount of ankylosis of the joint. Put the fragments in good apposition, control the effusion into the joint, and prevent movement, and you get a good result. In fractures of the metacarpal bones, put the parts in position, put the pad near the joint, put on a splint, and bandage it firmly.

Dr. E. P. Cook, of Illinois, stated that in fractures of the lower end of the radius, the application of the posterior splint is all that is necessary. One case of this kind he had treated by applying a closely-fitting kid-glove to the hand, and a close bandage over the fracture, with direction to lay the arm on a pillow in any position that was most comfortable. The result was perfect.

Dr. Roberts stated that he had not attempted to bring out anything new, but merely to present some of the more common errors for discussion. He agreed with Dr. Peck, that many fractures would be better treated without any splints than the ordinary splints. In fractures of the upper end of the humerus, it was better, in most instances, to let the arm hang vertically. Sometimes, however, it is best to let the arm fall forward. In many cases we need no splints at all. If we reduce the fracture, the interlocking of the fragments will ordinarily keep the fracture in place. If the fracture is comminuted, however, it should be treated with splints—*Cin. M d. News*.

## OVARIOTOMY IN BERLIN.

BY H. R. BIGELOW, M.D.

Dr. Martin's polyclinic furnishes him with an exceptionally large material, and during five weeks just gone by he has completed considerably over 100 operations. His statistics are creeping up to those of Schroeder, whom he may soon pass, and his results are *extremely* good. With such large experience, with such daily association with grave disease, and with such facility of technique, it is not surprising that success should follow him. He arrives at a diagnosis speedily and almost faultlessly, and operates rapidly and with signal coolness. Dr. Duvelius, himself a surgeon of reputation, is his first assistant, another administers the anæsthetic, while another, in conjunction with an intelligent matron, handles the instruments, sponges, etc. Dr. Martin sits between the knees of his patient,

and the two assistants are also seated. The galvanized iron operating table invented by the matron has an arrangement by which its middle third can be dropped, thus facilitating the placing of the dressings. Every one looks comfortable, and I am quite impressed with the advantages of this plan. The first assistant sits at the left of the patient, manipulates the abdominal parietes, keeps the intestines out of the cavity, covering them with a hot towel, and secures all bleeding points. The operations in abdominal surgery are all made in a special room, devoted exclusively to this class of work. It is literally saturated with carbolic spray. All the water used is boiled, and everything and everybody are made as aseptic as possible. The hair of the patient is shaved from the pubes, the abdomen is washed with brown soap and water, then with bichloride solution and then with lemon juice. The temperature of the room is kept well up, but even a higher grade, I think, might be advantageous. The tumor being removed and the stump being sewn up, the left hand is passed into the cavity behind the stump to the posterior cul-de-sac, the right hand then pushes a long pair of forceps through and into the vagina, an ordinary rubber drainage tube is then pulled through into the peritoneal cavity and left *in situ*. The other end drains into *the vagina*. Not altogether a safe proceeding, it seems to me, but where the results are so good it is hypercriticism to find fault.

His operations for total extirpation are done in another room.

The merit of Martin's procedure is that there ought to be very little blood lost and that the bleeding points can be easily made out and secured.

After making the first or posterior incision the vaginal wall and peritoneum must be firmly united by at least four sutures, and the incision should not be continued until all the bleeding has ceased, then it can be carried around, sutures being made as one advances. The only really difficult part of the operation is in getting hold of the lig. lata and passing the thread. If the uterus should be friable, or if the posterior adhesions are intimate and extensive, there will always be trouble.

Of Dr. Gusserow's and Dr. Landau's practices I have already written so fully (letters in the *Journal of the American Medical Association*) that in attempting anything further I should only be recapitulating. They represent the more conservative element of gynecology, a branch that is rapidly assuming large proportions and which has built up a well earned position among those whose clientèle numbers the rich and affluent. I do not know how largely they make use of the many adjuncts which characterize such fashionable practice at home, and whose use is very generally attended with such marked improvement in symptoms, but I do know that they are not so prone to amputate cervixes as many others, and that they believe much

in persistent, patient watching, judicious local applications and strict hygienic detail. I have seen both of these gentlemen do many abdominal sections. I have been present at eight ovariectomies by Landau, in all of which I had the honor of assisting; all of which did well, although some of the cases were attended with marked difficulties, the adhesions being general and the pedicle broad and juicy. At Dr. Gusserow's I have also seen a number of laparotomies and a quantity of plastic work, the results of which I do not know exactly, but in a general way I may say they were good. Dr. Gusserow's strong points are diagnosis and pathology in gynecology, and very general excellence as an obstetrician. His lectures on differential diagnosis and on the evolution of tumors are models.

Why should I speak of Prof. Schroeder, whose reputation is as wide-spread at home as it is in Europe. As a didactic lecturer he stands without a rival. He enunciates clearly and impresses his own individuality upon everything he says. To unrivalled excellence as an operator he adds the quality, somewhat rare, of a splendid teacher. He operates sitting on the *left* side of his patient, and is assisted by Dr. Hofmeier. Just as at Martin's so here, everything is done under the fullest antiseptic precautions.

Neither Schroeder, Martin, Landau or Gusserow use a *trocar*, but the contents of cysts are allowed to pour over the rubber sheet covering the patient and drip into a tub placed at the foot of the table. Neither are any especial precautions taken against reduction of temperature, save that at Prof. Gusserow's hot towels are placed on one side of the patient. I do not know that it makes any difference to the patient whether the trocar is used or not, but the operation looks better and is more cleanly when it is used. But I do maintain that it is good practice to supplement the heat of the body with hot bottles, and to expose only so much of the trunk as is *absolutely* necessary. Of the value of *strict* antiseptics there is no question in Berlin, and to it, in addition to the dexterity of the operators must be attributed the good results that obtain here. An analysis of the world's statistics, if such could be made, would show a percentage vastly in favor of such usage, for even the limited analysis that I have been able to draw when writing my papers on "American Ovariectomies," and later on "Laparotomy" (*American Four. of Obstetrics*) have convinced me that the operator who neglects to make use of every precaution in an abdominal section commits a serious mistake. In these days of advanced pathology, when our knowledge of wound repair has altered and advanced, with similar changes in our conception of a *contagium vivum*, we cannot afford to sneer, whatever individual good luck we may have had without such precaution. I think no intelligent surgeon will for a moment

claim, that mere soap and water will cleanse the hand from the low order of parasitic origin which may cling to it from handling an infected part of the body, from removing stitches from a suppurating wound, or from making an examination of diseased cervix. Experiment has proven conclusively that soap and water will not do this. Knowing this, has any man the right to risk a human life to his super-sensitive prejudices. Much less is it in good taste to belabor with bitter invective those who are more cautious, and perhaps a grain more advanced in scientific research. Take away antiseptic surgery, and see what the results would be. I do not believe that gynecologists here realize the advanced position of their specialty in America, and in how many things they could be instructed in our leading Polyclinics. Apart from Emmet and Goodell they know little of our good men, and of the splendid work they are doing. For this reason I rejoice that an opportunity, in the meeting of the International Congress, will be given them of "liberalizing" their ideas. The amount of material in Germany, especially here in Berlin is simply enormous, and of course the opportunities of examination and of making diagnosis are superb, far ahead of anything of the kind, even in our largest Polyclinics. So to, *ex necessitate rei*, the opportunities of personally acquainting one's self with abdominal surgery are many, as such operations are being done constantly. In obstetrical, practical work too, with such enormous material, there must be advantages for superintending and managing a great variety of cases of labor, which the student at home cannot have. In Pathology and Diagnosis the Germans are admirable. But in minor Surgical Gynecology, in Conservative Gynecology (embracing Rest, Treatment, Massage, Electricity, and the use of new remedies for limiting pain) in surgical appliance and surgical neatness, and the treatment of misplaced uteri, the gynecologist here can learn much from us. I have seen case after case here, operated upon or burdened with a pessary. I have seen numberless cervixes cut off, and uteri injected, where it seemed to me, the primary thing to do was to rest the nerve pain, to ease the cry of an overtaxed system that was wearing itself out, and to build the system up after the plan of Weir Mitchell and Goodell, before attempting any local interference whatever. This treatment may not be as showy, but it is more effective and infinitely more logical. I cannot reconcile myself to such wholesale slaughter of cervixes, or to such constant local interference without any regard whatever to the more pronounced bodily necessities, and I wish with all my heart, that Goodell's lecture "The Nerve Counterfeits of Uterine Diseases" (*Medical News*, December 6, 1884) could be read by every specialist here. It stands out as a novel of elegant English, and of deep insight into the real cause of half of the

suffering met with. This field is as wide, yes wider than that of operative surgery, for it covers a larger number of cases, and it is just here that the Americans are peculiarly strong. Emmet's last edition is very highly spoken of and rightly so, for it is unique in its honesty and thoroughness. Nothing can exceed the kindness of Prof. Gusserow and of his assistants towards medical men from abroad, and his clinic is a most popular one. To him, and to Dr. Wyder, his first assistant, as well as to Drs. Landau, and Martin I am under the greatest obligations. Prof. Schroeder was also most courteous in inviting me to his operations, and I am very appreciative of his kindness. — *Obstetric Gazette.*

### RENAL CALCULUS; NEPHRO-LITHOTOMY; CURE.

UNDER THE CARE OF MR. BERKELEY HILL.

E. R —, a woman aged forty, was admitted to the hospital on Oct. 28th, 1884. She stated that about three months previously she began to suffer from a gnawing pain in her right loin, which shot down to her right groin and knee; the pain came on suddenly, and was attended by vomiting. About a week later her urine was thick and red, but not, she thinks, due to blood. She passed urine frequently during both day and night; she never noticed any blood in it.

On admission the patient had occasional attacks of pain in her right groin and thigh; she had some tenderness in the right loin, but it was doubtful if any fulness was present there. Her urine was acid, had a specific gravity of 1080, and contained an abundant deposit of pus. She remained only three days at the hospital at that time, but she was re-admitted four months later, and then stated that during the interval the attacks of pain had been more severe. Her urine was acid; it had a specific gravity of 1010, and contained a large quantity of pus, and on one occasion was dark-brown from mixture with blood. There was a slight fulness in the right loin, and during deep inspiration the kidney could be felt, and it was rather tender. From the persistence of the symptoms and absence of others connected with the bladder, Mr. Hill concluded that there was a calculus in the right kidney; and on March 11th, 1885, he exposed the kidney in the loin and punctured it in several places with a needle, but he did not strike a calculus. He next explored the surface of the kidney thoroughly with his finger and detected a hard substance at the lower part of the organ near the hilus; towards this point, guided by the position of the tip of his finger, he passed a knife through the kidney and struck the calculus. Finding it closely embedded in thick layers of fibrous tissue, he then enlarged

the incision in the hilus of the kidney, and after freeing the calculus with a scoop, he extracted it with his finger. The wound was closed, except at the posterior part, where the drainage-tube was placed; carbolic gauze dressings were applied. During the first forty-eight hours after the operation the watery fluid, probably serous, not urinous, which drained from the wound was too great for the antiseptic dressings to retain. Notwithstanding this, the wound remained aseptic all through. About eight hours after the operation the patient passed about three ounces and a half of urine per urethram; it contained pus. Nine hours later she passed an ounce and three-quarters of urine, which contained much less pus. During the first twenty-four hours after the operation the total amount of urine passed was only twelve ounces, which contained thirty-nine grains of urea; during the next twenty-four hours twenty-seven ounces of urine, containing 106 grains of urea, were passed. The quantity of urine excreted increased day by day, until it reached forty-nine ounces, containing 364 grains of urea, during the sixth period of twenty-four hours. On the fourth day after the operation the pus entirely disappeared from the urine and remained absent for about six weeks, and then returned in slight amount. The patient had no return of the lumbar pain. She was discharged seven weeks after the operation; there was then a little pus in the urine, and the wound in the loin was almost healed. The calculus weighed 142 grains; it had an irregularly conical shape, and measured an inch across its base and along the two longest sides; the apex of the cone was smoothed off, and was represented by a flat facet, which seemed to indicate that it lay in the kidney against another calculus, but although this was carefully searched for at the time of the operation, it could not be detected. The patient was seen again on May 15th, when she was in generally good health. She said that she had felt pain in her right loin during that day for the first time; the wound had healed, and there was no fulness or tenderness there; her urine was turbid with flocculent pus.

*Remarks by Mr. BERKELEY HILL.*—The above case of nephro-lithotomy was very successful, though disappointing. It was successful in that a correct diagnosis of a renal calculus could be made on the presence of three symptoms—persistent pain in the loin, shooting thence towards the groin, the presence of pus in acid urine, and occasional slight hamaturia at the onset of the case; successful also in that the calculus was found and removed without difficulty through an incision into a healthy kidney from the loin, with the effect of removing the symptoms from which the patient suffered. But the case is also disappointing in that after the urine had been free from pus for six weeks, and the pain in the loin relieved, there should be a return of the purulent discharge. It is difficult to explain this relapse,

unless we conclude that there is still another calculus in the kidney, and this view is somewhat supported by the existence of a flattened surface on the irregularly shaped calculus which was removed. This flattened surface was observed at the time of the operation, and I searched very carefully for another calculus, but failed to detect one, and attributed the surface to the stone having been moulded in a calyx which fitted it closely. It is possible that so long as the wound in the loin remained open the pus discharged itself through that channel, and that when the wound closed the pus was obliged to find a vent along the ureter. Meanwhile the patient is enjoying a state of health and complete freedom from pain which she has not had for some years past.—*Lancet*.

#### THE ADVISABILITY OF PERFORMING DOUBLE OVARIOTOMY WHEN THE DISEASE OF BUT ONE GLAND IS BUT LITTLE DEVELOPED.

In performing the operation of ovariectomy, it happens in a certain number of cases that whilst cystic disease is so well pronounced in one ovary the other organ presents only a pathological state in its early development. When this latter condition is observed, a question must arise in the mind of the operator whether both ovaries shall be removed at one operation or whether the one least disturbed by pathological processes shall be left for a subsequent operation. The mortality from a double ovariectomy is undoubtedly larger than where a single ovary is removed, as has been shown by the statistics of Sir Spencer Wells and Kæberle. The fact that the patient is rendered sterile by the removal of both ovaries is also a point to be considered. The many sides to these questions have been discussed and a partial settlement seems to have been reached in favor of delay in removing the second ovary unless cystic disease is so pronounced in both ovaries as to make their removal a matter of urgent necessity.

Quite recently some statistics have been offered which seem entitled to consideration. In a paper entitled "Two Ovariectomies in the Same Patient" (*Med. News*, August 1, 1885,) the author, Dr. Ransohoff, of Cincinnati, discusses the question which gives the title to this article. Dr. Ransohoff disputes the statement made by Scanzoni that in fifty per cent. of cases both ovaries are affected. "In 366 operations for the removal of ovarian growths witnessed by Doran, the tumor involved both ovaries in 48, and in 20 other cases, 'suspiciously enlarged' ovaries were removed after the tumor had been cut away. Thus, in 18 per cent. of his cases both ovaries were affected. In 132 ovariectomies, Goodell found it necessary to remove

both ovaries in 50 per cent of all cases. In 293, 101, 229, and 56, and 1000 operations made, respectively by Kæberle, Tait, Keith, Olshausen and Spencer Wells, double ovariectomy was necessary in 37, 27, 13, 9 and 82. While according to the experience of Wells, both ovaries must be removed in 8 per cent. of all cases: according to that of others, double ovariectomy is indicated in 16 per cent. of all cases."

Dr. Ransohoff suggests that an examination of statistics will show that different operators are far from agreed as to what constitutes sufficient disease in the second ovary to call for its removal. It is the determination of this point which makes the decision a matter of practical difficulty at the time of operation. It is here that a strong judgment and an intelligent view of the conditions observed in the case will come to the material aid of the operator. The youth and conjugal relations of the patient present questions involving the propriety of removing both ovaries at one operation. Dr. Ransohoff's suggestion, "unless the less diseased gland be the seat of quite marked multilocular cystic degeneration, it would probably be better in many cases to leave it undisturbed or to empty the cysts of their contents," is worthy of practical consideration.

He has an eminent authority in Sir Spencer Wells in advocacy of this plan which he practiced on a girl of 19, from whom he had removed the right ovary. "The left ovary was enlarged to nearly double the normal size. Two follicles, about the size of cherries, were distended by clot. These I laid open, turning out their contents. It seemed hard to unsex a girl of 19, and if the disease should progress, a second ovariectomy could still be done. This operation was performed in November, 1864. After her marriage the patient gave birth to four children, and when last heard from, in 1881, she continued in good health."

In 32 cases, collected by Dr. Ransohoff, in which the operation was twice performed on the same patient, children were borne by five of these cases. The aggregate number of children borne between the two operations was fourteen.

Another important factor in favor of conservatism in dealing with a slightly diseased second ovary is the small mortality attending second ovariectomies. This mortality is estimated at about 12 per cent. Wells' experience shows a mortality of 34 per cent., whereas 51 per cent. in the cases reported by Kæberle have died. Dr. Ransohoff is very pronounced in favor of removing each ovary by a separate operation when the pathological condition of the ovary will admit of its retention. He concludes that double ovariectomy should be refrained from except in women approaching the climacteric, and unless the disease in the second ovary be quite pronounced.—*Maryland Med. Journal*.



**RAYNAUD'S DISEASE.**—At a recent meeting of the Clinical Society of London (*Medical Times*, May 30, 1885), Dr. Colcott Fox exhibited two adults affected with this disorder, and read notes of the cases. A woman, aged forty-one, of extremely nervous temperament, dated the commencement of the disorder from ten years back, but though this was the period when her attention was attracted by pain, it is probable that she suffered from slight attacks for some years previously. In the earlier stages all her fingers continually went "like white wax." This condition of recurrent local syncope gradually gave place to local asphyxia, and the feet became involved. The fingers gradually lapsed into a state of chronic asphyxia, which intensified by frequent attacks of more severity, often leading to "blood-blisters and ulceration." The nutrition of the phalanges has suffered greatly, so that her hands are crippled, the fingers are fusiform in shape, livid, shiny, and withered, the nails variously distorted, and the end phalanges much atrophied and almost immovable. The nose and ears are affected to some extent on exposure. Cold and nerve shocks are ready exciting influences. The second case, that of a man, aged fifty-one was of considerable interest from the fact that, like one of Raynaud's cases, he suffered from diabetes. His hands were not deformed, but he had suffered for several years from "dead fingers." He sought Dr. Fox's advice for symmetrical gangrenous patches on the skin, which recurred, and later for an attack of asphyxia of one great toe and lower third of the inner side of the leg, and then it was found that he had been attacked in a similar manner, though more severely, in the other toe, and on another occasion blood blisters had formed beneath the ends of his toes. Dr. Fox concluded his paper by giving a reference to some cases which have been recorded as scleroderma of the extremities. A woman with the latter disease was shown to illustrate the difference between it and Raynaud's symmetrical gangrene of the extremities.

In the discussion which ensued, Dr. Barlow reminded the Society of three cases which he had brought before it in a previous session. From subsequent observation of these cases he had been led to some conclusions with respect to treatment, and especially by means of the continuous current. In one case, that of a man aged forty-two, in whom repeated attacks of the disease had caused almost complete inability to walk, he had employed the continuous current with very satisfactory results, a gradual improvement in the circulation having taken place during the eight months during which the treatment was applied, and remaining permanent after its discontinuance. He had found that the most satisfactory method of using it had been by the application of both poles of the battery to the affected part and by painting the surface with one

of them. In two other cases he had employed the constant current by means of baths during the attacks of extreme pain, and had succeeded in cutting short the seizure at once. He had used nitrite of amyl, on the strength of Raynaud's opinion that the disease was due to spasmodic contraction of vessels, and, although the general physiological effects had been produced, there had been no relief afforded. He should recommend the use of the constant current persevered with for several weeks, and followed by frequent shampooing. He believed that its action was simply that of a local stimulus.

**REMOVAL OF TONSILS.**—Dr. De Saint-Germain gave some very practical remarks on this common operation that we are so often called upon to perform in the winter season. He said, "You noticed that I just refused, notwithstanding the entreaties of the parents, to perform the operation of extirpation of the tonsils in this child, although I performed it in two others. The fact is that this simple operation is not without danger in certain cases. How shall we know when not to operate? Well, there is a rule that you should never forget: it is never to cut the tonsils until they touch each other in the median line. It has been said that a child that has enlarged tonsils is subject to phthisis or to get diphtheria, but it is not true; large tonsils don't exercise such an influence over the general health. There are cases when you should refuse to operate. When you see the mucous membrane inflamed, and you see white spots, don't operate; wait, and under treatment it will regain its usual rosy color. Ought the tonsils to be cut at all ages? No. If the child is under two, wait, for fear that a loss of blood, however slight, may weaken the patient. From four years of age up to twelve is the period for operating. At twelve, if it is a girl, wait, for very often at this period or later menstruation may come on, and it will modify the condition so that no operation will be needed. From seventeen to nineteen, and in adults, hemorrhage may be feared. Here always remain at least an hour with them after the operation. As a last counsel, don't operate at all when there is an epidemic of diphtheria. Having decided to operate, what are the means used to perform the operation? All of you know the amygdalotome, so I won't describe it. I wish to say that I think it will pare or scrape the tonsil, but it will not extirpate it, so that some other doctor has often to be called in to complete the operation that you have left unfinished. It is, besides, an instrument that is difficult to keep clean, and I have seen the knife-edge break off and fall into the pharynx, so that I do not use this instrument at all. I use concave bistouries. The convex side is put against the adherent portion of the tonsil, and the concave side is towards the base of the tongue. Right and left instruments are

used. With these instruments you can pluck the gland out of its socket completely, but you need a special pair of forceps. These are long pincers, made so that they will not tear the substance, with triangular teeth that are flat, with a sort of gutter between, exactly like a small waffle iron, from which you have so often enjoyed eating the cakes. Place the pincers horizontally, and the child will instinctively open its mouth wide, so that nothing remains but to cut the tonsil."—*Med. Times*.

**INDUCTION OF PREMATURE LABOUR.**—Dr. T. Gaillard Thomas, of New York, writes as follows regarding the induction of premature labor (*Med. and Surg. Rep.*, Feb. 14, 1885): The method of inducing premature labor which I now invariably adopt is very simple, and, at the same time, a perfectly efficient one. The patient is placed across the bed, with the buttocks resting near the edge, and under her is arranged a large piece of rubber or oil-cloth in such a way as to drain into a tub below on the floor. In this tub we put one or two gallons of water at a temperature of 98 F. The operator stands between the thighs of the patient, whose knees should be properly supported, and employing a syringe with a long nozzle, which is carried up as far into the cervical canal as it will go, he keeps a steady stream directed against the membranes. In the course of ten minutes the os will be the size of a silver half dollar, and when dilatation to this extent has been accomplished, he is to insert a gum catheter between the membranes and the uterine walls. The patient is then put in bed, and that is all.

This operation constitutes one of the greatest advances that have ever been made in the obstetric art, and it is certainly no mean triumph to be able thus to preserve a human life which, without its aid, would have been inevitably lost. I can point to at least two dozen children in this city who by this means were saved from an untimely fate. When the infant has been delivered before full term, it should not be washed and otherwise treated in the ordinary manner of nurses, but should be carefully wrapped in warm cotton and allowed to remain in it, the temperature of the room in the meanwhile being brought up to nearly one hundred degrees.

[This mode of dilatation should be found useful in rigid os at full term. Its application may be found greatly to alleviate the first stage, especially in primipara.]—ED. LANCET.

**THE ELASTIC BANDAGE IN STRANGULATED HERNIA.**—The elastic bandage is so decided an improvement on the old-fashioned truss, and is so simple a contrivance in itself, that it is a matter of surprise that its palpable advantages should not have been recognized sooner. Though preferable to the truss in every form of hernia, it is especially in the

strangulated form that the bandage renders priceless service. Jakolew regards the application of the elastic bandage—next to an operation—as the most effective method of eliminating an incarcerated hernia, and speaks with confidence of its usefulness, even after the failures of taxis (*Centralblatt für Chirurgie*, No. 11, 1885). According to this author there are various modes of origin of an incarcerated hernia, as can be seen in herniotomy or in an autopsy. Each origin, as far as it can be ascertained, will, of course, call for a special form of taxis, but the bandage will be equally useful in all cases. The permanent, mild and uniform pressure of the bandage on the intestinal loop mostly results in either pushing the intestinal contents backward into the afferent or onward into the efferent portion of the loop, removing the strangulation in either case. Experiments on the cadaver have amply proven these results. The danger of gangrene is to be cautiously guarded against; persistent, violent, or even considerable pain is sufficient cause to discontinue the bandage. If, after the use of this bandage for ten to twelve hours, no symptoms of improvement appear, the usefulness of this treatment must be acknowledged, and no other means resorted to. Jakolew reports the successful employment of the bandage in five cases out of six, though some cases grave symptoms and failure of taxis had preceded.—*Therapeutic Gazette*.

**PALLIATIVE TREATMENT OF CANCER OF THE UTERUS.**—Dr. J. E. Burton thinks we are too apt to be discouraged when treating this disease, and to do nothing when the disease is in an advanced stage. Four measures can always be taken with more or less success:

1. We can attempt to bring about a more healthy action in the parts.
2. We can relieve pain.
3. We can moderate discharges, especially those of blood.
4. We can remove the fetor of the discharges.

He suggests that the progress of a neoplasm can be checked, at least for a time, by exciting an inflammation which shall affect its immediate surroundings. Such a cordon of inflammation might be excited by the application of iodine or iodized phenol. He quotes Duploney for considering that concentrated acetic acid is the most satisfactory for such a purpose. Gaillard is much in favor of the actual cautery, which he thinks might be used freely as often as once in three weeks. Of other caustic agents, nitric acid, acid nitrate of mercury, bromine, sulphuric acid, bichromate of potassium, and resorcin have been used by the author, and are all of benefit in certain cases. Before caustics are applied to an exuberantly granulating surface, the granule-

tions should be scraped away as thoroughly as possible.

For the relief of pain nothing better than opium, in some form, by the rectum, can be given. To diminish the vaginal discharge any reliable astringent injection may be given. Subcutaneous injections of ergotin will have a good effect in controlling hemorrhage.

The fetor, which is so offensive, can be controlled by vaginal suppositories of iodoform used night and morning. The author has also found that Chian turpentine lessens the quantity of the discharges and the tendency to hemorrhage—hence it is not valueless. He thinks a spare diet is to be preferred when it is possible.—*British Med. Jour.*, June.

**EARLY DIAGNOSIS OF TYPHOID FEVER.**—Dr. Hardy calls attention to the following symptoms which he regards as in a certain sense characteristic of typhoid fever in the earliest stages (*L'Union médicale*, No. 6, 1885): There is cephalalgia, most often frontal, but sometimes occipital, and radiating into the neck, which may be somewhat stiff. The patient lies habitually on the back, and seldom moves. The face is somewhat pale, the countenance without expression, in general serious and grave, and a smile is seldom provoked. When the person is addressed directly he answers briefly and in monosyllables, although the intelligence is at this period usually unimpaired. There may be a little delirium at night, and insomnia is very constant. The tongue is red at the edges and at the tip, but whitish on the dorsal surface. The spleen is increased in volume. Diarrhœa, when present, is accompanied with iliac gurgling. The temperature is elevated, but the pulse is not very frequent, is full and resisting, and sometimes dichrotic, though this is of less common occurrence than is generally supposed. The urine is usually diminished in quantity. The so-called *tache cerebrale* is readily produced; but of more importance, as more especially diagnostic of typhoid fever, is the *corde musculaire*. If the biceps muscle be pinched between the thumb and index-finger and snapped, like a guitar string, a circumscribed contraction will occur at that point, with the formation of a hard, tense swelling, which disappears after a brief period. If the patient, in whom no well-defined local trouble can be discovered, presents all the above-described symptoms, the diagnosis of typhoid fever can, Dr. Hardy claims, be made with almost absolute certainty.—*N. Y. Med. Record*, June 20th. *Anæsthetic*.

**NURSING SORE MOUTH.**—In all cases of nursing sore mouth, there may be found, upon careful inquiry, wrong of the uterus. There is nearly always more or less leucorrhœa, and the discharge is frequently of an offensive, irritating character. The internal administration of eupatorium, alternated or combined with hydrastis, will always help in

such cases, and they will many times accomplish every thing desired.

R Mother tincture eupatorium aro-  
maticum . . . . . 3 ij.  
Fluid hydrastis. . . . . 3 ij.  
Water . . . . . 5 iiii. M.

Sig.—One teaspoonful every hour.

It is surprising to see how rapidly some cases of nursing sore mouth heal under the influence of this simple prescription. The burning mouth and tongue are cooled; the leucorrhœal discharge is modified, lessened, and not infrequently entirely stopped; and the nervous element of the disease, characterized by morbid watchfulness, throbbing headache, etc., is perfectly controlled in most cases. Eupatorium is said to be a remedy for nervousness, but we have never observed that its virtues were very marked in this regard except in this terrible disease, so frequently met with in nursing women, but here it certainly is a first-class remedy.—*Amer. Med. Jour.*

**AN IMPROVED FRACTURE-BOX.**—Dr. S. Bradbury, of Oldtown, Me., sends us a photograph representing the "box and railway" devised by himself for the treatment of compound fracture of the leg. The box is the ordinary fracture-box of every-day use, but the improvement consists in mounting it upon four grooved wheels riding upon two rails. He writes: "I have just removed the apparatus from a patient who had a compound comminuted fracture of the middle and lower third of the left leg, and I believe it the best apparatus for this kind of injury which we possess. The railway is screwed to the cross-bar at the foot of the bed, and rests upon a good hair-mattress. The leg is placed in the box, and imbedded in bran, which is retained in its place by a piece of sheeting laid in the box. The great advantage of the railway is that it prevents the ends of the upper and lower fragments from being crowded together by any movement of the patient during sleep. If the patient moves up or down, the box slides with the leg, and no harm is done. The attendants of the patient above referred to, told me that this would often happen while he was asleep, the trucks riding to and fro over the rails without the least disturbance to the position of the leg in the fracture-box.—*Cin. Med. News*.

**ARSENIC IN ANEMIA AND ATROPHIC CONDITIONS.**—In the *Lancet*, 1885, p. 653, Dr. Wilks contributes an article on arsenic as a therapeutic agent. The author states that arsenic has a great influence in curing cutaneous affections of a gouty origin, and therefore it is not surprising that the same remedy has great power in preventing attacks of gout. In the same way, many gouty patients who suffer from neuralgia are cured by means of

arsenic. In some forms of nervous affection, the author has found it quite unique in its action, and he mentions the case of a lady who suffered for years from neuralgia in the eye-ball, which was only relieved during the times she took arsenic. The most remarkable effects of arsenic are seen in the cases of anemia and various forms of cachexia and atrophy. Many cases of what have been styled "pernicious anemia" have been cured by five-minim doses of liquor arsenicalis given three times a day, and two cases in which Addison's disease was suspected were completely cured by giving arsenic. In cases of wasting and general cachexia its action is most efficacious, where there is no malignant disease nor other organic disease to be detected as the cause of the wasting. To say that the remedy is always successful is more than can be supposed; but, where every other means has failed, it is worth the trial to give this remedy in the form of the liquor arsenicalis in doses of from four to five minims three times a day.—*London Med. Record.*

**THE SUMMER DIARRHOEAS OF INFANTS.** The *Medical Age*, of Detroit, contains, in its issue for July 25th, a valuable article on this subject, by its editor, Dr. J. J. Mulherson. He treats first of the causes of these affections, dividing them into simple diarrhoea, entero-colitis, and cholera infantum, and then speaks of the treatment as follows:

"*Simple Diarrhoea.*—Assist the efforts of nature to rid the bowel of irritant matter with a dose of castor-oil. Follow this by sufficient doses of prepared chalk to correct the acidity of the discharges, give opium to diminish the peristaltic action, and give astringents and strychnine to restore tonicity. The following is a good formula for a child of, say, eighteen months:

Tr. opii camph. .... ̄ ss. ;  
Ext. rubus villos. fl. .... ̄ j .  
Tr. nucis vomice. .... ̄ gtt. xij ;  
Mist. cretae. .... q. s. ad ̄ ij.

M. Sig. A teaspoonful every three hours.

"*Entero-Colitis.*—When the character of the stools, the elevation of the temperature, the disturbance of the stomach, etc., indicate the involvement of the intestine in a catarrhal inflammation, the means employed in the simple diarrhoea, which is usually the precursor of these graver symptoms, must be supplemented by other remedies. Place the child on small doses of calomel and ipecac—say a twelfth of a grain of each for a child of eighteen months—every two hours, alternated with a teaspoonful of an infusion of five chamomile flowers in a cup of boiling water. The spice poultice, moistened with hot brandy, must be laid over the abdomen. If the temperature pass over 101° F., it must be reduced by baths, the water of which must at first be tepid, and gradually cooled to 70°

F., or lower, as the circumstances of the case require. Should twenty-four or thirty-six hours of this treatment be followed by no improvement, and the stools continuing or becoming more colliquative, I have found the following formula to answer admirably, quieting the irritability of both the stomach and the bowels:

Creasoti ..... gtt. iv. ;  
Zinci oxidi. .... gr. xvj ;  
Tr. belladonna. .... ̄ ss. ;  
Glycerini. .... ̄ ss. ;  
Aquam. .... q. s. ad ̄ ij.

M. For a child a year old: Sig. A teaspoonful every three hours. This may be alternated with aromatic sulphuric acid, two drops in ten drops of brandy, every three hours. The spice poultice should be continued.

"*Cholera Infantum.*—Bearing in mind our conception of this affection as a neurosis, our treatment should be directed, first, to destroying the organisms, on which every fermentation depends for its development; secondly, to allaying the irritation of the end organs of the splanchnics in the mucous membrane; thirdly, to arresting the outward osmosis of the vessels; fourthly, to lowering the febrile temperature and removing the algid condition. My experience leads me to speak with favor of salicylic acid and chalk, as recommended by Dr. Hutchins in the September, 1880, number of the *Proceedings of the Medical Society of the County of Kings, N. Y.*, as a remedy meeting the first and second of these indications. This combination is useful only in cases of serous diarrhoea, having no efficacy in the inflammatory or lenteric form. It acts happily, also, in allaying gastric irritability. Three grains of salicylic acid, rubbed up with two grains of prepared chalk, should be given every three hours. Care should be taken that the chalk be pure, and that, during the effervescence attending the addition of water to the powder, no odor of chlorine be emitted. Such odor denotes the presence of chlorine—a residuum of the manufacture of chlorinated soda. It is apt to exist in prepared chalk, and should be carefully avoided. The creasote formula, given above, for entero-colitis, has also answered a good purpose, especially in cases attended with much gastric irritability.

"There are few cases of cholera infantum in which the bromide of potassium will not prove helpful, and especially where there exists restlessness, wakefulness, and twitching of the muscles. It allays the irritation of the splanchnics, and of the nervous system generally.

"Baths hold an important place in the treatment of the fever of cholera infantum, and for one reason, among others, that it is of little use to administer medicines as long as the temperature is elevated. The soothing influence of a cold bath

on a child whose temperature has reached, say, 103° F., and the increased activity of the drugs administered after the bath, need but to be witnessed to make converts to this much neglected remedy in the treatment of cholera infantum. The child should be immersed up to its neck in water at a temperature of 95° F., to which cold water should be added until the bath reaches 70°, or even lower, the condition of the patient, his temperature, etc., being the guide to the reduction. No hard-and-fast rules can be laid down to govern the temperature of the bath or its frequency. The condition of the infant must be the guide, which the good sense of the physician must be trusted to interpret and follow.

"When the child has entered the algid stage of the disease, treatment offers little hope of rescue. Alcoholic stimulants and warm baths are about the best we can apply. Belladonna, through its action on the heart, suggests itself as a remedy in this condition; and experience has shown it to be of value. By paralyzing the terminal inhibitory filaments of the pneumogastric, it gives the heart over to the sympathetic, and we have, as a consequence, increased rapidity of contraction and raised arterial tension—a condition of affairs which it would seem very desirable to secure in the cold stage."

#### THE TREATMENT OF HÆMORRHOIDS BY INJECTION.

—Under the above title is an article by Dr. Charles B. Kelsey, of New York, in the *American Journal of Medical Sciences* for July. Dr. Kelsey is a strong advocate of the essentially modern method of the treatment of piles by injections of carbolic acid. The acid is of varying strength. He has three solutions constantly ready, one of fifteen, one of thirty-three, and one of fifty per cent. He sometimes uses the strong acid. In a severe case he would begin with the strongest solution; in a mild case, in one of the weaker solutions. He finds this method to be comparatively painless and uniformly successful.

The famous Western "pile cure" is composed of equal parts of strong carbolic acid and sweet oil, of which half a dozen drops are injected into each pile.

Dr. J. M. Matthews, of Louisville, gives the following rules: (1) Use the acid only in the smallest tumors. (2) Should it be used in a large tumor, inject once only in one portion, and wait several days, and then inject another portion. (3) Use the smallest amount possible in injecting, say one to three drops of the mixture of sweet oil and carbolic acid.

The injection turns the pile white, coagulates the blood in its vessels, and results in its shrinking away without the inflammation being severe enough at any one time to prevent the patient from attending to his business.

**BATHS FOR RHEUMATISM.**—Turkish baths are now prescribed in New York for those forms of rheumatism resulting in deformity of the joints. The baths are taken twice a week and for half an hour's duration. Several ladies who have passed through the alkaline treatment find that these baths afford them great relief.

The medicine which seems to give the most satisfaction is aqua ammonia, in twenty drop doses, three times a day, in a half tumbler of cold water, the bicarbonates of potassa and soda are objectionable, because they are liable to produce a skin disease resembling herpes.—*Med. Sum.*

**TREATMENT OF PSORIASIS.**—While on skin-diseases, it may be well to give M. Guibout's treatment of psoriasis. Here we reach the acme of irritant treatment, as the trouble is a sort of mummification of the skin and transformation into a sort of shell, dry and crackling, without a shadow of vitality. The indications are to remove the epidermic scales and try to revive the lost vitality. The external treatment consists in friction and baths. The substances employed by M. Guibout are: the oil of cade extracted by distillation from the *Juniperus Oxycedrus*, and next in order pyrogallallic acid. The oil of cade gives the best results. The whole of the body is well rubbed with it twice a day with a piece of cloth or flannel; then every other day a bath is given with from five hundred to six hundred grammes of subcarbonate of soda in it. If the treatment with pyrogallallic acid is preferred, it should be combined with vaseline (ten to fifteen grammes of the acid to one hundred of vaseline), used in friction twice a day, and alkaline baths to follow. The pyrogallallic acid turns the skin black when exposed to the air: so it must not be used on the face or neck, at it takes a long while to get rid of the color.—*Med. Times.*

**HOMŒOPATHS IN THE BRITISH MEDICAL ASSOCIATION.**—In the report of the Council, presented at the recent meeting at Cardiff, and published in the *British Medical Journal* we find this statement: "The Council have had under their consideration the subject of admission and retention of homœopaths as members of the association during the past year. An enquiry has been made throughout the thirty-three branches, and the result has been that there is evidence to the effect that a large majority of the members are adverse to the admission of homœopaths as members, but an equally large proportion are opposed to the idea of the expulsion of those members who have already gained admission into the ranks of the association."

An excellent local application for the relief of neuralgia and gout is prepared by rubbing up together equal parts of thymol, menthol, camphor and chloral.

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science**

**Criticism and News**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

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## MEDDLESOME MIDWIFERY.

Some of our best thinkers have called a halt in midwifery practice. It is felt that at the present rate of advance we shall soon overtake Nature, and relegate her to a back place. Those of us who have some lingering respect for Nature, and some doubt as to the propriety of converting a physiological function into an automatic movement, regulated only by the skill and boldness of the artist, will be glad to know that protests, more or less pronounced, have been entered in several highly respectable quarters. To be just, it is proper to say, that there have always been a "remnant" who refused to be carried away on the antiseptic wave, and whose confidence in the power and completeness of the natural forces remained unshaken. Nevertheless, it must be confessed that the rank and file, no less than many eminent persons, have been borne along on this most captivating and popular wave. But a little longer and woman would have been declared unfit to deliver herself unaided, or if, perchance she did, to survive the process, unless sealed against noxious germs. But every hobby, and every practice, not well grounded, will have but its day, and so now, judging by what we read, all the fancy obstetricians are beating a hasty retreat. The principal danger now seems to lie in the probability of their being carried as far back by the ebb as they were carried forward by the flow. And thus it ever has been with the

human mind, not only in the domain of medicine, but in all fields difficult or impossible to define with mathematical precision. The theorist and experimentalist is essential to progress, no less in obstetrics than in other departments; but we would all prefer that somebody else's wife or sister should be the subject of all doubtful practices. In the short cycle of our lives many queer things happen us. It now turns out, according to the evidence, that it is quite possible to complete the process of parturition by natural forces alone. Nay, more; that the chances of woman's survival are greatly enhanced by a policy of non-interference.

In the Maternity Hospital, N. Y., out of 570 deliveries the death rate was 2.67 %. A few years afterwards, under "reform," the death rate rose to 6.67 %. Thus in 1881, out of 202 selected cases, 12 died. Of 423 cases, occurring from April, 1881, to April, 1882, but 2 deaths took place from puerperal fever, and the whole mortality was greatly reduced. These last cases were all strictly treated on the non-interference plan. Previous to the adoption of "reform," the death rate was not above the minimum in the N. Y. State Hospital for immigrants. A year since, a so-called "reform" was instituted there; the prophylactic injections and complicated manipulations were introduced, and with the direct and immediate effect of increasing the mortality rate, which became alarmingly high. At the same time, "there were on Ward's Island a large number of Russian Jewish refugees, who were filthy and despondent. Upwards of 90 of these women were delivered without a death. There were numerous forceps deliveries, but there was absolute non-interference in the after-treatment." From other quarters also comes evidence of a similar character. These figures are not probably free from inaccuracies. A mental bias is capable of presenting misleading statistics, even though the intention be honest. One thing, however, can be said in their support, namely, that for the long ages antecedent to fancy midwifery, woman was able to bring forth her young, and, to a remarkable degree, fulfil the Scriptural injunction laid upon her, to "multiply and replenish the earth."

But we would here file a caveat. We would not intentionally discredit the great work accomplished for the relief of woman in the hour of her distress

and peril, nor say anything to dim the halo of glory which crowns the host of brilliant and self-denying workers, whose names are found in this field of labor. We fully recognize the fact that nature may be assisted by art in the physiological act of parturition, and that, even in normal cases, a judicious use of known means, may, sometimes, be resorted to with advantage for the relief of pain and shortening the duration of labor. Having admitted this much we may very properly be asked, whether there be, after all, such a thing as "meddlesome midwifery." No doubt of it. It is of two kinds, and may be classed as scientific and unscientific. The representative of the latter class, fully conscious of his lack of skill, but desirous of earning his fee and making a show, at once removes his boots, and takes up a position on the bed or couch, where he holds the fort until the agony is over. With each pain his digit finds its way into the vagina, now correcting this, and again that, and with groans and grimaces tugs away, until at last by his herculean efforts delivery is accomplished. But his work is not yet completed. "The after-birth is grown fast to the side and must be removed." A few pulls at the cord, or a rude introduction of the hand, and this is accomplished. Nothing now remains but to pompously claim credit for conducting "a bad case" to a successful and happy issue, and to retire covered with glory. This is no overdrawn picture, but a true representation of what is enacted in many cases every day, even in Canada, where the profession is fully up to the average, both as regards character and skill. Were this serio-comic performance a mere sham, devoid of positive harm to the patient, however degrading to the performer, it might be dismissed in few words. But such is not the case. Constant manipulation of the soft parts causes a dryness, and irritation painful to endure, to say nothing of the increased danger of introducing septic matter. Nor is this all. One of the tricks of these meddlers is the introduction of the finger within the os, at each pain, for the purpose of dilatation. The cervix is probably more frequently lacerated from this cause than the passage of the child. Such meddlesomeness is harmful, exceedingly indelicate, and in all respects most reprehensible.

In considering the question of undue interference on the part of the scienced and skilled obstetricians, anæsthetics and the forceps naturally

suggest themselves first. The administration of chloroform and ether has been quite fashionable for a long time, especially in American cities, not in operations merely, but to allay the ordinary pain of labor. When we consider the continued depressing effects of these drugs, given in so simple a case as the extraction of a tooth, it surely cannot be regarded as a light thing to bring the parturient woman under their influence, not merely for a few minutes, but for hours together, it may be. The exhaustion caused by ordinary labor is soon recovered from, but not so the depression induced by chloroform or ether, which sometimes continues for days, marked principally by impairment of the digestive organs. The state of general muscular relaxation induced by anæsthetics predisposes to hæmorrhage, which is another strong objection to their uncalled-for use. Some authorities to the contrary, there can be no doubt that anæsthetics prolong labor. It would be easy to give both reasons and illustrations in support of that statement. It has often been said, that the forceps, as a rule, are not used early enough. This is no doubt true, but it is also true, that they are used too early, and when uncalled for, which, perhaps, is a still greater evil. Much depends, too, on whose hands hold them, for however learned we may all be, we are not all skilled workmen, capable of handling deftly any tool placed in our hands.

The use of antiseptics in ordinary cases, and under ordinary circumstances, is, to say the least, uncalled for. Both vaginal and intra-uterine injections are useful in their place and ought not to be omitted when required. It does not by any means follow that every parturient woman must be antiseptically treated. The post-partum conditions being natural, or physiological, any interference is more likely to interrupt than accelerate the restorative process. Of course, when there is reason to fear danger, owing to the severity of the labor, the use of instruments or exposure to contagion, it would be fanaticism to decline the use of antiseptic injections. But no prophylactic treatment can ever supersede general good management, cleanliness being always accorded the first place. Antiseptics may come and go, and all kinds of new-fangled theories and practices, but that obstetrician who has most faith in Nature, and who makes patience, discrimination, cleanliness and moderate conservatism his guiding star, will be able to show a record second to none.



## VALUE OF SANITARY WORK.

The inestimable value of sanitary work in the maintenance of public health cannot be too frequently brought under the notice and attention of the profession and the public. Dr. Baker, the indefatigable secretary of the Michigan State Board of Health, has recently issued a circular setting forth the good results to health from sanitary work to which we desire to give special prominence. He says: Sanitary authorities have claimed that the work which they have recommended to be done as a preparation for cholera—such as preventing and abating nuisances; attending to drains, sewers, privies, and cesspools; cleaning up generally, and unusual carefulness in regard to foods and drinks—would reduce the sickness and deaths from other diseases, even if cholera did not come. The weekly reports for July, 1885, to the Michigan State Board of Health, by physicians in different parts of the State, indicate that this claim is being realized in Michigan, so far as relates to the lessened sickness—it having been lessened from nearly every disease, and greatly lessened from fevers and from diarrhoeal and other diseases believed to be especially influenced by sanitary conditions; and this is true notwithstanding the fact that the meteorological conditions in that month were rather more than usually unfavorable to health. It is proper to state, however, that the sickness in any month is influenced by the meteorological conditions in the preceding month, and that the meteorological conditions in June, 1885, were favorable to health.

Observations in Michigan for many years have shown that in July the meteorological conditions especially unfavorable to health are: high temperature, excessive humidity of the atmosphere, and deficiency of ozone. The bulletin of "Health in Michigan, July, 1885," says: "For the month of July, 1885, compared with the average of corresponding months for the seven years, 1879-1885, the temperature was slightly higher, the absolute and the relative humidity were more, and the day and the night ozone were less." Compared with the average for the months of July in the seven years, 1879-1885, remittent fever, intermittent fever, dysentery, consumption of lungs, cholera infantum, diarrhoea, cholera morbus, measles, and whooping-cough were less prevalent in July, 1885." A large part of this decrease in sickness has undoubtedly

been due to the medical and sanitary journals and the newspapers, which have constantly kept before the people the necessity for sanitary work, and the facts as to the spread of cholera in Europe.

It remains to be seen to what extent efforts for the exclusion of cholera from this country, and the general preparation for cholera by boards of health and the people, shall prove effectual: but even if cholera shall not be entirely prevented, there will remain the belief that the measures which have so greatly decreased the sickness from other diseases cannot but have had their influence in decreasing it: and if cholera does not occur in this country it seems quite probable that, by reason of the suffering elsewhere, there may be as many cases of serious sickness prevented in this country as there have been cases of cholera in Europe. But this may not continue without continued vigilance and effort.

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## CANADA MEDICAL ASSOCIATION.

The following are the papers promised up to the 19th ult. for the Chatham meeting: Dr. Osler (Philadelphia), "The Clinical and Pathological Relations of the Cæcum and Appendix;" Dr. A. Grant (Ottawa), "Aortic Aneurism, with a specimen;" Dr. W. B. Geikie (Toronto), "Retroversion of the Gravid Uterus;" Dr. Burt (Paris), "Internal Urethrotomy;" Dr. Holmes (Chatham), "Puerperal Mania;" Dr. Kerr (Winnipeg), "Fractures in the Neighborhood of Joints;" Dr. Fenwick (Montreal), "Amputation of the Breast, with cases;" Dr. Bethune (Wingham), exhibition of specimens: 1. "Parasite from an Abscess of the Thigh," 2. "Aneurism of the Pulmonary Artery;" Dr. Worthington (Clinton), "Epidemic Cerebro-spinal Meningitis;" Dr. Fulton (Toronto), "Subperiosteal Amputation;" Dr. Campbell (Seaforth), "Trephining the Mastoid Bone;" Dr. Rutherford (Chatham), "Supra-Pubic Urination;" Dr. Lett (Guelph), "Inebriety, a Disease the Result of Physical Causes;" Dr. A. H. Wright (Toronto), "Phlegmasia Dolens;" Dr. McKeough (Chatham), "Pilocarpine in Puerperal Eclampsia;" Dr. J. E. Graham (Toronto), "Dissecting Aneurism of the Thoracic Aorta, with specimen;" Dr. Shepherd (Montreal), "Excision of the Tongue;" Dr. Alloway (Montreal), "Puerperal Septicæmia;" Dr. Ryerson (Toronto), "Atrophic Nasal Catarrh;"

Dr. Atherton (Toronto), "Abdominal Section for Uterine Myomata;" Dr. Nattress (Toronto), "Field Hospitals in the North-West Territory;" Dr. A. E. Hanna (Lansdowne), "Enlarged Prostate;" Dr. Gardner (Montreal), "Double Uterus, with specimen;" Dr. Oldright (Toronto), "Pernicious Anæmia;" Dr. Ames (Brigden), "Rattlesnake Bite;" Dr. Wilkins (Montreal), "Specimens illustrating the Infective Nature of Tuberculosis;" Dr. Stewart (Montreal), "The Curability of Chronic Infantile Paralysis."

There is every prospect of an important and successful meeting, and we trust that all who can will be in attendance.

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### OBITUARIES.

**HON. DR. E. A. VAIL.**—It is with great regret that we announce the death of Dr. Vail, of Sussex, N. B. He has been connected with the government of his native province for many years and was well known for his many good qualities. He was born in 1817, studied medicine in Edinburgh, and graduated in Glasgow University, in 1837. Although he did not seek public honors, his personal popularity led to his nomination and election in 1857, since which time, with few intermissions, he has continued to represent his county in Parliament. He was one of the most skilful and popular practitioners in New Brunswick, and was held in high esteem socially.

**DR. ALFRED JACKSON.**—In the death of Dr. Jackson, of Quebec, another of the links that join the past with the present generation has passed away. He had attained the ripe age of 75 years, nearly half a century of which was spent in the practice of his profession in the Gibraltar of America. For many years he occupied the important position of Dean of the Medical Faculty of Laval University. He was one of the oldest and most respected practitioners in Quebec, and will be missed by a large circle of friends and relations.

**DR. W. G. METCALF.**—The news of the assassination of Dr. Metcalf, Superintendent of the Kingston Insane Asylum, by one of the lunatics confined therein, was a painful surprise to his many warm friends in all parts of the province. Dr. Metcalf was one of our most promising young alie-

ists. He had been schooled at the feet of the venerable father of alienists, Dr. Joseph Workman, and had already attained great eminence for a man of his years. He fell a victim to that system of kindness in treatment with which he had been indoctrinated during his early career. He was born in Uxbridge in 1859, and was therefore in his 38th year at the time of his death. He studied medicine in the Toronto School of Medicine, and graduated in Toronto University in 1872. Soon after, he commenced to devote himself to the treatment of the insane, in which he had already acquired great success. He leaves a young wife, and a daughter by a former marriage.

**DR. W. H. McDONALD.**—The very sudden and unexpected death of Dr. McDonald, of this city, took all his friends by surprise. He appeared to be in perfect health up to the time of his death, and was actively engaged in his professional round of duties. The deceased was about 30 years of age, and was a most promising physician for his years. He was gold medallist of Trinity University, and although only a short time in the city had acquired an excellent practice. The cause of his death is supposed to be heart failure, probably occasioned by the use of some medicinal agent.

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**ACUTE DYSENTERY.**—Prof. Da Costa administers ipecacuanha, in twenty grain doses, every two or three hours, guarded with opium, and has had very marked results from this plan. It is especially good in puerperal dysentery, as Prof. Bartholow has pointed out. The opium plan (one-half grain every two hours) is also very good. Rochelle salts one ounce in divided doses in the first twenty-four hours and less thereafter. This does not preclude the simultaneous use of opium. Both the ipecacuanha and the saline purgative plans should be abandoned in two days, if no change in the condition of the patient is seen; they are rapid or valueless in their action. Next comes bismuth subnitrate, ten to twenty grains every two or three hours. The use of ice-water injections three or four times a day was originated by him some years ago, and are valuable in many cases.

**PILOCARPINE IN PNEUMONIA.**—Pilocarpine seems to be growing in favor in the treatment of pneumonia—especially double pneumonia. It is claimed

that the delirium so common in double pneumonia is due to a uremic cause; hence profuse perspiration will relieve the congested kidneys as well as relieve the lungs to some extent. Carefully given, pilocarpine can do no harm in pneumonia, and is worthy of trial in one-eighth grain doses hypodermically; some advise a fifth or sixth grain dose to procure profuse perspiration.

**TREATMENT OF EPISTAXIS.**—The following, says the *Lyon Médical*, is the procedure employed by M. Siredey for controlling epistaxis in typhoid-fever patients. Introduce up into the nostril, for a considerable distance, a piece of fine sponge of the size and shape necessary to enable it to enter without difficulty, previously soaked in lemon juice, or vinegar and water. The patient should be kept lying on the face for a length of time, with the sponge in place.

**SMALL-POX IN MONTREAL.**—The number of cases of small-pox in Montreal during the past month has been considerably increased, and a serious epidemic is threatened. The disease is chiefly confined to the French-Canadian population, and its prevalence and malignancy is owing to the fact that as a class they persistently refuse the protective influence of vaccination. The number of cases among the vaccinated is comparatively small, and the mortality is very light. There is no better evidence of the protective power of vaccination to be found than that furnished by the statistics of small-pox in Montreal.

**THE NEW ORLEANS EXHIBITION.**—The New Orleans World's Exposition is again to be re-opened on the 10th of November next, under the name of the North, Central and South American Exposition, and continue open until the 1st of April, 1886. The prospectus of the new company announces a greater and more interesting exhibition than that of last year. A large number of the former exhibits have been allowed to remain and the demand for space from new exhibitors has been very great. Those who failed to see the World's Exposition will now have an opportunity of seeing one of the largest exhibitions ever held on the continent.

**MURIATE OF AMMONIA IN NEURALGIA.**—Dr. Darling, of Brooklyn, N.Y., (*Thera. Gazette*) recommends muriate of ammonia in half drachm doses,

every half hour, until three or four doses have been taken, and regards it as a specific for facial neuralgia. He continues the remedy in smaller doses three or four times a day for a few days after the neuralgia subsides. He also advises its use in a similar way for tooth-ache.

**APPOINTMENTS.**—Dr. J. J. Gardner has been appointed Prof. of Anatomy, and Dr. J. B. McConnell Prof. of Histology, in Bishop's Medical College, Montreal.

Dr. Clarke, of Rockwood Asylum, has been appointed Medical Superintendent *vice* Dr. Metcalf, deceased, and Dr. Millman, of London, assistant Dr. D. A. Bowlby, of Simcoe, has been appointed assistant Physician at the Toronto Asylum in place of Dr. Robinson, who has been transferred to the London Asylum.

**COMPLIMENTARY DINNER.**—Dr. Horsey, Surgeon to the Midland Battalion, and Dr. Grant, jr., attached to A Battery, were tendered a complimentary dinner by the Ottawa Medico-Chirurgical Society on the occasion of their return from service in the North-West. Deputy Surgeon-General Roddick and Dr. Boyd were also present as guests.

**MILK AS A VEHICLE FOR POTASSIUM IODIDE.**—Dr. Keyes, of New York, recommends the administration of iodide of potassium in milk, in the proportion of ten grains to the gill. It is easily retained on the stomach and large quantities of the drug can be taken in this way.

**BRITISH DIPLOMAS.**—Drs. J. H. B. Allen (McGill), D. Gow (Trinity), and H. Bascom (Toronto), have been admitted Licentiates of the Royal College of Physicians, London.

We learn from the *Lancet* that Dr. Keith, the well-known ovariologist, has just returned from a short visit to America, whither he had been summoned to give his opinion upon a serious case. This is said to be the first instance, since the Declaration of Independence, of America having summoned medical aid from the old country.

WE desire to draw the attention of our readers to the new dress which adorns the present issue, No. 1, Vol. XVIII. The letter-press has been set up in an entirely new font of type made expressly for the LANCET.

## Books and Pamphlets.

**THE CLIMATE OF CANADA AND ITS RELATIONS TO LIFE AND HEALTH**, by W. H. Hingston, M.D., L.R.C.S., Edin., Surgeon to Hotel Dieu, Montreal, etc. Montreal: Dawson Bros.

We are much pleased to welcome this excellent work by Dr. Hingston on the above named subject. Many of the papers which constitute the work were read before the Natural History Society of Montreal, and formed part of the annual course of Somerville lectures. Many additions however have since been made, and we have in the volume before us a very interesting and valuable work on the climate of Canada. The first 94 pages are devoted to the physical qualities of our climate, the second part to its influence on life, and the third part to its influence on health. The work contains a large amount of original matter which no one could furnish who had not access to French sources of information. It will be remembered that the author read a paper on this subject last year, before the British Association for the advancement of Science, which did him the honor of selecting him from the ranks of the profession as Vice-president of the Association. The book has been written during the spare moments of an active practice within the past 25 years, and the author is to be congratulated upon his success in this literary venture. He has shown himself as much an adept with the pen as with the surgeon's knife. The work will well repay a careful and attentive perusal.

**A SYSTEM OF PRACTICAL MEDICINE.** By American authors. Edited by William Pepper, M.D., LL.D., Prof. of Practice of Medicine, University of Pennsylvania. Assisted by Louis Starr, M.D., Prof. of Diseases of Children, University of Pennsylvania. Vol. II. Philadelphia: Lea Bros. & Co. Toronto: Hart & Co.

A short time ago we noticed the first volume of this excellent work, and we now have the pleasure of calling the attention of our readers to the second volume. It contains the concluding section on general diseases, and diseases of the digestive system. The authors are Dr. Jacobi who writes upon rachitis; Dr. Tyson, diabetes mellitus; Dr. J. Solis Cohen, Dr. W. W. Johnston, and Dr. J. T. Whitaker, on diseases of the digestive system; Dr. Bartholow on diseases of the liver, and Dr. Alonzo Clark, on peritonitis. We have already spoken

highly of this work, and see no reason to change our opinion after a perusal of the second volume. It is a faithful presentation of American medicine, and should be read by every practitioner.

**MINOR SURGICAL GYNECOLOGY.**—A Treatise on Uterine Diagnosis and Gynecological Practice, including Gynecological Operations. For the use of advanced Students and Practitioners.—By Paul F. Mundé, M.D., Professor of Gynecology at the New York Polyclinic, etc. Second edition, revised and enlarged, with 311 illustrations. New York: Wm. Wood & Co.

The above work of 350 pages embraces the practical part of the interesting subject of gynecology, and will be favorably received by the general practitioner, for whom it is specially intended. The book is divided into three parts. Part I, Gynecological Examinations; Part II, Minor Gynecological Manipulations and Applications; Part III, Gynecological Operations. The present edition is a great improvement upon the first edition, published in Wood's Medical Library some years ago. Though not exhaustive, it is full of useful practical hints, and deservedly merits a generous reception at the hands of the profession.

**CHOLERA: ITS NATURE, SYMPTOMS, HISTORY, CAUSE AND PREVENION**, with an outline of the Germ Theory of Disease, by J. B. McConnell, M.D., Prof. of Materia Medica, etc., Bishop's Medical College, Montreal. Montreal: R. Miller, Son & Co. 25c.

The above named monograph was prepared for one of the Sommerville courses of lectures, but became so extended as to be delivered only in an abridged form. It is an interesting and comprehensive compilation on the subject of cholera, and, in view of the anticipated visitation, will be welcomed by the profession.

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## Births, Marriages and Deaths.

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On the 5th of July, H. T. Corbett, M.D., Winnipeg, formerly of Ottawa, aged 45 years.

On the 15th of July, Alfred Jackson, M.D., of Quebec, aged 75 years.

On the 31st of July, Hon. E. A. Vail, M.D., of Sussex, N.B., aged 68 years.

On the 16th ult., W. G. Metcalf, M.D., of Kingston, Ont., aged 38 years.

On the 20th ult., W. H. McDonald, M.D., of Toronto, aged 29 years.

# THE CANADA LANCET.

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## Original Communications.

### NOTES ON THE SURGERY OF THE KIDNEY.

BY LAWSON TAIT, F.R.C.S., BIRMINGHAM, ENG.

N. B., æt. 32, was sent to me by Mr. Gordon Nicholls, in March, 1884. She had had for some years a dull aching pain in the region of the right kidney, and it steadily increased until a tumor could be distinctly felt. She had passed large quantities of blood in the urine and had become extremely anæmic. When I saw her the tumor was as large as a foetal head and was clearly fluctuated. On the 22nd of March I explored the kidney and found the pelvis distended with urine; there was no suppuration. The ureter was widely distended, as far as the finger could reach. I removed the kidney, because I could not reach the calculus, which I believed to be impacted in the ureter. Very little urine was passed on the 22nd and 23rd, 14 ounces passed on the 24th, 20 ounces on the 25th, 34 ounces on the 26th, and the quantity steadily increased until, on the 15th of April, it was 46 ounces, and she left the hospital on May 1st, passing nearly 50 ounces each day. On May 12th a careful examination of the urine was made and it was found to be perfectly healthy. This patient speedily regained a healthy appearance and has remained perfectly well.

E. H., æt. 19, was operated upon by Mr. J. W. Taylor, for a ruptured kidney cyst, on August 2nd, 1883, the case being published in detail in the *Lancet*, Oct. 4th, 1884. A persistent and very troublesome urinary fistula remained, which, when any attempt was made to allow it to close, gave rise to the most complicated general symptoms; it was therefore resolved that we should remove the kidney, and this I did on November 20th, 1884. The patient made a very good recovery. On the

day of the operation only two ounces of urine were passed, but on the third day after, this increased to 25 ounces, and somewhere about this quantity was maintained until December 11th, when it rose to 32 ounces, and this quantity of secretion was sustained until the patient left the hospital on the 30th of December. The wound healed quickly and the patient regained her health. She was seen about a fortnight ago, when pus was still discharging from the wound, but otherwise she was perfectly well.

K. I., æt. 45, sent to me by Dr. Bottle with a large tumor of the right kidney, which felt perfectly solid, no fluctuation being discernible. On April 16th I proceeded to remove the kidney, and found, only after it had been dislodged from its bed to an extent of more than two-thirds of its bulk, that it consisted of a series of deep-seated abscesses. The patient died of shock, about six-and-twenty hours after the operation. In this case the mistake was made of not exploring the kidney before attempting its removal. If I had opened it and passed my finger through its hypertrophied texture towards the pelvis, I should certainly have discovered the true nature of the disease. As it was, I took it for a solid tumor.

A. V., æt. 38, came to me as a hospital patient in April of this year, with a large tumor of the right kidney. I performed nephrotomy, April 20th, 1885, opening a large number of abscesses, from which cheesy pus was discharged in large quantities. I fastened in a drainage tube, and the patient went home on the 4th of May, very much improved. Owing to unfavorable domestic circumstances, her health speedily broke down, and when next I saw her she was so exhausted and broken up that I did not see my way to advise the more serious operation of removing the kidney, which I had contemplated if her health had improved.

A. T., æt. 22, came to me as an out-patient at the hospital, in May of this year. She had been married for five years and had two children, the youngest being twenty months old. For about a year she had been conscious of a tumor on the right side of the abdomen, which could only be felt in certain positions, and which moved very freely about. It was a source of constant pain, and this pain was aggravated very greatly at the menstrual periods. On examination, I first dis-

covered the tumor just on the right side of the bodies of the lumbar vertebræ, above the brim of the pelvis. When the abdominal walls were perfectly flaccid I could move this tumor in almost any direction, right across the vertebral column to the left side, upwards as far as under the liver, and down quite into the pelvis. From this mobility and the extreme and incessant pain, which was without any doubt at all, referred to the tumor itself, I had no hesitation in diagnosing it as a morbid growth of the ovary or tube, with an extremely long pedicle. I advised its removal, and proceeded to perform the operation on May 20th. When I opened the abdomen I found, very much to my surprise, that the tumor was not as I thought; it was the right kidney enlarged to about three times its proper size, and capable of being moved under the peritoneum in every direction. It did not possess any kind of mesonephron, but moved freely between the peritoneum and the subjacent tissue, very much, apparently, as one can move a warming pan between the sheets of a bed. In fact, it was what I had never seen before, a really movable kidney. As the organ seemed to be diseased, and as I could not bring myself to believe that its great mobility was the cause of the pain, I opened it and failed to find any calculus or suppurating disease. After having satisfied myself that the left kidney was quite healthy, I removed it. The patient made a very easy recovery. The amount of urine rose to nearly 30 ounces a day, before she left the hospital on the 9th of June. I have seen her within the last few days, in perfect health and quite free from pain. Dr. Suckling examined the kidney for me and expressed the opinion that it was the subject of fatty and cirrhotic alteration.

On removal, the kidney weighed 9 ounces, and the merits of the case certainly oblige me to alter to some extent what I have previously said, concerning movable kidneys. I have never seen anything in the least degree like the condition of the present case. Kidneys enlarged by general growths are very often remarkably movable, but anything like the mobility of this kidney I never saw. It may be that this mobility was the cause of its diseased condition, but I can hardly bring myself to accept that explanation, it being to my mind much more likely that its disease, to a large extent, was the cause of its mobility. I do not therefore think

that I should have done any good to the patient by fixing it in position by stitching.

M. R., æt. 25, was placed under my care in May of this year, at which time she told me she had had pain in the right lumbar region for about six months, which pain was not increased on exertion, but if she engaged in horseback exercise, of which she was very fond, she inevitably passed blood in the urine. Dr. Suckling, who was associated with me in the treatment of the case, examined her with great care and expressed the opinion that the kidney area on the right side was considerably larger than that on the left. He had seen her in consultation with two other surgeons before I saw her, and at that time had been impressed with the belief that she had a calculus in the right kidney. But this belief was not shared in by his colleagues. On examination, I satisfied myself that the right kidney was larger than the left, and the symptoms were so definitely and clearly given by the patient and her husband, who was a medical man, that I came to the conclusion that the patient was actually suffering from renal calculus. As she was about to return to South Africa, the question became a very serious one as to whether she ought to return in her present condition, or be subjected to surgical interference before she started on her journey. When the question was put to me, I had no hesitation in expressing my view, that to allow a woman in her condition to pass into the wilds of Caffre Land was simple madness, because she would probably return to us with the kidney disorganized and her health seriously affected. In this view I was not supported by those who had previously seen the case, but upon my advice the patient submitted to nephrotomy, which I performed on May 23rd, and removed a large branching renal calculus. A drainage tube was inserted in the wound and the patient made a very rapid and satisfactory recovery, the only curious feature of the case being, that as long as the drainage tube was retained in the wound all the urine passed through the normal channel, but as soon as I removed the drainage tube, apparently, the whole urine of that kidney passed through the wound in the loin. Repeated trials disappointed in this way for about six weeks, when a final trial was successful, and the wound, on July 28th, was very nearly healed and the patient quite well.

E. E., æt. 52, found that her urine was thick

and offensive smelling, with occasionally blood in it, for more than two years, and during that time she had suffered from severe aching pain in the right and left loins. I found a large tumor in the position of the right kidney, and Mr. Taylor found the patient was suffering from mitral regurgitation, advised her to have nephrotomy performed, and this I did on June 16th, removing a large calculus from the pelvis of the kidney. I left a drainage tube in, but practically no suppuration occurred and the patient went home on the 27th of June, with her wound quite healed.

J. W., æt. 45, had a large painful tumor on the right side, slightly to the right side, but mostly lying over the vertebral column; it clearly fluctuated and was freely movable. It was diagnosed as a cyst of the mesentery. I opened the abdomen for the purpose of removing it on the 18th of June, and at once came upon a thin-walled cyst containing about three pints of clear fluid, and after emptying it I endeavored to shell it out from the folds of the mesentery under which it appeared to lie. This I succeeded in doing, until I came upon a fresh substance, which speedily pronounced itself to be the kidney. I had in fact been dealing with a case of hydronephrosis, in which the pelvis of the kidney had become so completely dilated that the body of the organ itself lay quite behind. Of course I had to complete the operation by removing the kidney itself. Only one ounce of urine was passed on the day of the operation, but the quantity steadily rose until it was 30 ounces, when she left for home on July 4th. She has since remained in good health and the wound is perfectly healed.

E. G., æt. 59, was admitted to the Women's Hospital in July, with a large tumor of the right kidney. She had been engaged for many years in making her living as a midwife, and had suffered a good deal during the growth of the tumor, which occupied some five or six years. She had been strongly advised not to have any operative interference, but to let the thing alone. I however advised her differently and she accepted my advice. I performed nephrotomy on July 13th and removed a very large calculus from the pelvis of the right kidney. She made an easy and rapid recovery and went home on the 27th of July.

REMARKS.—The surgery of the kidney has now advanced to such a stage that we may speak pretty

positively of what can, and what ought to be done in all cases of tumors of this organ. What I have to say now is very much a repetition of what I have said in previous papers on this subject, with the exception that I have had, as I have already indicated, to modify somewhat my belief concerning movable kidneys; but even here I can confirm much of what I have already said on the question. This abnormality is so rare that this is the first case I have ever seen, in a practice which now extends over twenty-five years and which includes forty operations upon the kidney and more than twelve hundred abdominals. The second point deserving notice is, that all of these forty operations, with one exception, have been performed on the right kidney, a circumstance which certainly is very remarkable and must be something more than a mere coincidence. Some months ago, in a communication made to the Obstetrical Society, I told the story—now some fifteen years old—of an interview I had with a Board of Examiners, whom I could not satisfy concerning the treatment to which I would subject a patient submitted to me for the purpose of the examination, and who was burdened with a large suppurating tumor of the kidney. I told the Board that I should remove the kidney, as everything else seemed to have been tried fruitlessly. In reply, they told me that my surgical enthusiasm seemed to be greater than my knowledge of the practice of medicine, and we parted, never to resume further association. A singular change has occurred since then, for the kidney promises to be one of the most brilliant fields for the achievements of new surgery. Out of my forty operations on diseased kidneys, including abscesses, hydatids, sarcomas, and stones in the pelvis, I not only had thirty-eight recoveries, but I have had—so far as I know up to the time of writing—complete cures in thirty-eight out of the forty operations. In the fortieth case I failed, because I did too much; I removed a kidney with a large number of chronic abscesses in it, when I ought simply to have opened it and drained it, as an expedient preparatory to its subsequent removal. This patient died of shock, and in this I learnt the lesson, which I shall always follow in future in such cases, of opening the kidney, in order to ascertain its condition exactly before I remove it. I really think that, in this conclusion, I have to sum up all my experience in renal surgery.



There can be no question that interference with the large malignant tumors, which we see in children under 14 and 15 years of age, is simply nonsense. Even if the little sufferers recover from the terrible operation which is performed in such a case, the disease will recur, and no good will have been done. But in all other tumors of the kidney, if the patient is sufficiently ill to justify interference, the disease may be attacked with a perfect certainty of procuring relief, in every case and complete cure in probably 90 per cent. I do not think it matters much whether the organ be attacked by what is called the abdominal method, or the lumbar, as far as the immediate success of the operation is concerned. But I have a strong preference in my own practice for the abdominal method, if there is any likelihood of its being decided to remove the kidney, for in this way the condition of the other organ may be ascertained before the diseased one is removed. If, however, it has been determined to perform nephrotomy, and the removal of the diseased organ is a question which has been dismissed, then I think the lumbar incision may be the preferable of the two. In such a case the operation of nephrotomy is an extremely easy one, and even the removal of the kidney is not a proceeding accompanied by much danger or difficulty, unless it has been too long delayed.

## THE TREATMENT OF TYPHOID FEVER.

BY G. T. MCKEOUGH, M.D., M.R.C.S.E., CHATHAM, ONT.

As many of the questions concerning the treatment of typhoid fever still remain undecided, some investigators continuing to look for a specific, whilst recognized authors differ upon essential points, a brief account of the treatment carried out in one hundred cases, with a mortality of only two per cent., may be of interest. This series of cases include all those under the care of my partner (Dr. Holmes) and myself, during the past four years. The series include no cases in which there could be any doubt as to their diagnosis; all forms of malarial fever, which might be mistaken for typhoid, having been eliminated,—such as remitting fevers of tertian or quotidian type, or those severe forms of malarial fever in which quinine not having been administered heroically at the onset, have assumed consequently a low “typhoid

state”; these fevers being also common to this district.

The form of treatment pursued might be termed expectant and anti-pyretic; the most assiduous attention being given to hygienic details, to the use of means to combat unfavorable symptoms as they arose, and to the adoption of measures to keep the temperature near the normal. The carrying out faithfully of these rules, with strict adherence from beginning to end, to the golden maxim laid down by Sir William Jenner, in his classical address on the treatment of typhoid fever, delivered before the Midland Medical Society at Birmingham, in 1879, viz., “give unceasing attention to little things,” have been the guides of our treatment. When a case is presented for treatment and reveals symptoms which would lead us to suspect that typhoid fever is developing, immediate confinement to bed is advised, in a capacious well-ventilated room. If the suspicions prove correct and typical symptoms unfold themselves, absolute rest in bed is ordered in the horizontal position, with occasional shiftings from side to side, to avoid fatigue, hypostatic congestion of lungs and kidneys, and any tendency to bed sores. This necessitates the constant use when required, of the bed-pan and urinal. A rigid adherence to these simple directions is strictly enforced in all cases, mild as well as severe, from the commencement of the treatment until convalescence is thoroughly established. The surroundings of the patient are carefully examined into, and endeavors made to exclude fresh accessions of poison, by the removal of any possible source of contagium.

If the sanitary conditions and arrangements of the place are very bad and facilities for transferring the patient are more easily carried out than the removal of the filth, the former procedure has been resorted to. Thorough ventilation is maintained constantly, day and night; in most cases it is advisable, perhaps, not to allow direct drafts, but where there is any tendency to hyperpyrexia, drafts, if the temperature of the patient is carefully watched, need not be dreaded; placing the patient without covering, even in winter weather, between two open windows has had decided beneficial effects in lowering the fever, and thus allaying distressing symptoms, the result of a high temperature. Positive quiet is maintained. No visitors are allowed admittance into the sick room,

and it is advisable and important that the nurse be not officious or talkative, but an intelligent person, who will carry out instructions carefully and judiciously. The walls of the sick room are bared and unnecessary articles of furniture removed. Strict attention is given to the cleanliness of the patient, sheets are removed and clean ones replaced daily. The stools are passed into a bed-pan, into which some disinfectant has been placed, and immediately removed and buried some safe distance from any habitation. Water is allowed *ad libitum*. The patient's diet is certainly one of the most important factors in the successful treatment of typhoid fever. It is essential that it should be liquid, that the weakened digestive powers may not be overtaxed, and that any source of irritation to the bowels may be avoided. As soon as the disease is suspected, with the advice "to go to bed," the patient is restricted to liquid food. In the great majority of our cases milk, to the amount of a quart given regularly in divided quantities, every twenty-four hours, is our mainstay. In some cases more can be given with impunity and without unfavorable symptoms arising. In this relation, I might say that we either examine personally the stools, or carefully inquire as to their general character and to the presence of curds in them. In others milk will not agree, or can only be given in moderate quantities. Some who object to milk will relish buttermilk; in others, still, we have to depend upon animal broths, beef peptonoids, etc. The latter preparation, in conjunction with peptonized milk, we have used of late with great satisfaction, especially if curds are found in the stools, or if there are marked abdominal symptoms. In this way the digestive powers are conserved, diarrhoea—if that exists—is lessened, less solid matter is left to undergo decomposition, and probably fever is lowered. For what is more common after an enema, which has brought away a quantity of offensive partially digested material from the bowels, than to see a restless patient with an elevated temperature, fall into a quiet slumber and his temperature drop several degrees?

Diarrhoea has not been a very troublesome symptom in the greater number of our cases: this may be due in part to the care bestowed upon the patient's diet. If there are not more than four or five alvine passages in twenty-four hours, no heed is paid to this symptom. If the discharges are

more frequent and exhausting, they are checked by enemata of starch emulsion, half a teacupful, as often as necessary. If this fails, a small quantity of Tr. opium is added to the emulsion. If the bowels instead of being relaxed are constipated, enemata of salt and water or thin gruel are administered daily. When deep ulceration is suspected, a small injection is given on alternate days only. When hard fecal masses accumulate in the rectum and an ordinary injection fails to produce the desired effect, a quarter of an ounce of inspissated ox gall dissolved in a cup of warm water, will produce a speedy evacuation, giving great relief. The non-administration of laxatives in any form is a *sine qua non* with us. When the stools are offensive, or there is much distension of the abdomen, charcoal is given in teaspoonful doses, mixed with cream, twice or three times a day; or, if this form of administration prove objectionable, it may be given in large capsules. From our experience with charcoal in this disease, when its need is indicated, we have always found it a most valuable and satisfactory remedy, by checking fermentation, limiting perhaps the multiplication of disease germs and maintaining an antiseptic action. The offensive character of the stools is corrected, abdominal distension abated and the temperature reduced. The cases in which obstruction of the bowels have been caused by its accumulation must be rare.

When hæmorrhage from the bowels occur, the strictest quiet in the recumbent posture is preserved, the food is limited to concentrated material that leaves but little solid residue, such as Liebig's Extract or beef peptonoids. Ice is given by the mouth, an ice-bag is applied to the abdomen and a mixture of gallic acid and Tr. opium is administered. The latter prescription we invariably have, at the bed-side of the patient in all cases after the second week, to be given if necessary, and we think life has been saved by this precaution, as some valuable time must elapse before a physician could be summoned. Directions are left for the preparation to be given immediately: although the *vis medicatrix nature* probably controls the majority of hæmorrhages from the bowels, it is well in the face of such a formidable symptom, to assist her and that right quickly.

Regarding the antipyretic part of our treatment, quinine is given freely in many cases in the early stage of the disease. The district in which we

practise is malarious and as a positive diagnosis is not always possible, the patient is given the benefit of the doubt and quinine administered. When the diagnosis is made, quinine is discarded, except in a few cases in which our usual method of reducing temperature is not applicable or objected to, when large doses are administered in the manner recommended by Wilson of Philadelphia, after the evening exacerbation has reached its height. The bath treatment was resorted to only in a few cases in which the fever ran high, the prevailing prejudice against it and its impracticableness in most houses prevents its general use; however, when it was applied, the results were excellent. But in the great number of cases the temperature was controlled by the systematic and regular use of iced whiskey or iced water and whiskey, the whiskey overcoming the popular prejudice of taking cold, applied to the outer surface of the body with a sponge; the use of a fan at the same time will greatly assist in the reduction of the temperature. By these means we have never failed to keep the temperature in the mouth or rectum ranging from 100° to 102° F. It is often necessary to prolong the sponging process and sometimes resort to it very frequently, but the benefit derived fully recompenses the trouble, irksome as it sometimes proves to the nurse. It is perhaps needless to state here that it is necessary that the attendant be properly instructed in the use of the thermometer.

The disturbances of the nervous system are often peculiarly trying. The headache and delirium of the first week may be alleviated by cold applications, the menthol point, cutting the hair, or if very distressing, the use of the bromides and chloral hydrate. Insomnia and its resultants—typhomania and coma vigil—may often be prevented by controlling the temperature from the first; but if these symptoms should supervene, alcohol, hydrate of chloral or opium may be required, for a fair amount of sleep must be secured in all cases. Alcohol we use only when failure of heart is threatened or to increase nerve energy, as indicated by tremor or delirium. And in those cases where the surface of the body is pale, the tongue dry and brown, with sordes, alcohol by paralyzing the vasomotor system in the periphery of the body overcomes this condition, relieves pressure in the internal organs, and does great good thereby.

The only medicine that we use routinely is nitro muriatic acid, well diluted, given because it is usually well borne by the stomach, aids the digestive process and favors the assimilation of food. Whether it has any specific antiseptic action or not is yet an unsettled question. I might add, in conclusion, that frequent examinations of the urine and lungs are important, as albuminuria and pneumonia, which sometimes complicate typhoid fever, might be overlooked at their invasion, unless searched for.

## HEMORRHAGE AFTER ABORTION\*

BY S. S. MURRAY, M.D., THORNDALE, ONT.

Having had a number of cases of uterine hemorrhage followed by a dangerous septic condition, I thought a consideration of the following cases would be of interest. It requires a very accommodating conscience to ascribe every fatal case to circumstances over which we have no control, and to attribute every successful case to our interference. Robert Liston said, "We must learn to look boldly on the open mouths of arteries;" we must learn to keep cool where we cannot see the arteries.

CASE I.—June, 1879. Miss A., æt. 19, aborted at third month. Found the patient blanched, having lost an immense quantity of blood; did not see the fœtus, as it had been disposed of. There was bilateral laceration of the os; removed placenta. In this case I injected a solution of ferri persulph. and plugged the vagina. On the third day there was a chill, factor of the lochia; temp. 102°. By washing out the uterus with acid carb., 1-20, this subsided; the patient made a slow recovery. In this case a solution of ferri persulph. was used, but, as has been shown by Paul Broca, it requires about thirty seconds to coagulate; but from the streams of blood from the sinuses, it could not coagulate it.

CASE II.—Mrs. S., æt. 32, hæmorrhage from organized clot, which was removed three weeks after abortion at about two months. The hæmorrhage in this case was not very free, but continuous, until the patient was becoming weak. In consultation, it was decided to remove what appeared to be organized clot, in amount about equal to a small walnut, and my friend, Dr. Moorhouse,

\*Read before the Ontario Med. Association, June, 1885.

will doubtless remember what a difficult job we had, removing it piecemeal and mainly by the finger-nail, which is better than the placenta forceps, unless there is plenty of room. The vagina had been plugged before operating. The lochia did not smell badly at any time; the patient made a good recovery.

CASE III.—Feb., 1882, A.B., æt. 23. Was sent for four days after abortion at between third and fourth months; the patient was blanched and had fainted, but on lowering the head she regained consciousness. The os uteri on examination was patulous, freely admitting the finger; the placenta was removed without much difficulty in badly smelling shreds, and further hæmorrhage was controlled by carbolized hot water injections, as hot as I could bear my hand in. The temperature in this case kept up to 103°, with chills for three days, but subsided after the uterus was washed out with carbolic injections. Nourishing diet, with two-grain doses of quinine, were administered every third hour.

CASE IV.—Mrs. G, æt. 22, primipara. Was called upon to treat her, in conjunction with her family doctor, for lobular pneumonia. During convalescence she aborted at the third month; there was considerable hæmorrhage. I suggested plugging, but her family physician thought hot water would control the flooding. It did so, but the placenta still remained. It is not necessary to describe the case in detail, but I may state that, for a period of fifteen days, there was more or less hæmorrhage, but no offensive discharge. She alternated between attacks of pneumonia and symptoms resembling malaria (but which doubtless arose from the absorption of the septic material from the retained placenta). She would not permit the uterus to be examined. Six days before her death the parotid and cervical glands gave indications of suppuration. After a further consultation, permission was obtained to irrigate the uterus, which brought away quantities of shreddy material, which smelled badly; but she gradually sank, and died thirty days after the abortion.

CASE V.—Mrs. T., æt. 18, primipara, aborted at fourth month. The next day I was called upon to treat her for an alarming hæmorrhage. Plugged the vagina, and after fourteen hours removed the placenta; there were no bad symptoms, the patient making a good recovery.

CASE VI.—Mrs. W., æt. 30. Was not called upon to attend this case until six months after the abortion. I found the following conditions, so graphically described by John Bell: "Pale, languid, and giddy; pulse flutters and is hardly to be felt; breathing is quick and anxious, accompanied with sighing and great oppression; heart palpitates on the slightest exertion, and the slightest inclination of the head or rising suddenly from the couch endangers fainting; voice is low; eye languid, colorless and of a pearly white; the flesh feels soft and woolly, and the skin is pale and yellowish—gelatinous and, as it were, translucent, like modelled wax; dropsy appears." This latter symptom was not very marked. She had attempted to work, but had fainted so often, that she was compelled to take to her bed. She was treated with hæmatics and quinine, and a generous diet. She is still under treatment, and it is doubtful if she will ever fully recover.

In summing up, we are to bear in mind that we are not dealing with a natural labor. The generative organs are not prepared for the strain that is put upon them. In a perfectly natural labor, the coagulating process is completed before nature is prepared to safely part with the placenta, or even manifests a disposition to expel it. The formation and presence of coagula, first in the placenta and then in the uterine sinuses, are the very agents that normally excite uterine contractions, and thus effect the expulsion of the placenta. In an abortion, on the other hand, the uterine muscular fibres are not developed, or very imperfectly, and being unable to perform their functions, the placenta is not expelled. In the normal state the placenta acts as an irritant, the uterus contracts upon it, thus forming a tampon; the contractions cut off the blood supply from the placenta, and it in turn tampons the uterine sinuses until the coagulum is formed in them. The blood thus cut off from the placenta goes to nourish the muscular fibres of the uterus, and in a little time they are strong enough to throw out the now unnecessary placenta. In a normal labor we ought to wait for from twenty minutes to one hour, until the coagulation process is completed. But in the cases we are considering, would waiting be of any service? At the end of three or four hours, or as many days, we find the placenta as adherent as ever, unless (as is commonly the case) it has become

partially separated, which fact is indicated by hæmorrhage; or we have the other condition, that of septicæmia. Playfair says, "that the one great primary cause of post-partum hæmorrhage is inertia." Therefore, to overcome the inertia, we should give ergot; then, in order to give time to act, plug the vagina, on removing which we very frequently find the placenta comes away with it. In Case 5, the removal of the cause stopped the hæmorrhage. Dr. Parish mentions a case of uterine hæmorrhage of three weeks, following a miscarriage at third month, cured by scraping with the wire curette, which simply brought away some granular matter. The application of the tampon is of great importance, as the pressure of the cotton on the uterus has a powerful effect. The best effects are obtained by not pressing each pellet of cotton too strongly, each one acting as an elastic ball; on removing these, I have found them quite elastic after fourteen hours. The vaginal orifice should close over the filling.

Concerning ergot, I have not found the various fluid extracts to act as well as an infusion of the powdered drug. If the cervix should not dilate sufficiently after using the plug, we might dilate with a tupelo tent, sufficiently to allow us to use the wire curette. Hundreds of women are sacrificed to the let-alone policy; exhausting hæmorrhage or fatal septicæmia is almost sure to follow a retained placenta. Dr. Paul F. Mundè has removed the secundines 57 times, with but one fatal result from septicæmia, and that was present before the operation. Some of the causes of hæmorrhage are, hæmophilia, mental emotion, functional disease of the liver, incautious use of stimulants, sudden assumption of the erect position; the local causes, irregular and insufficient contractions of the uterus, clots, portions of the retained placenta or membrane, retroflexion, laceration or erosion of the cervix, vagina or vulva, lacerations of the cervix being more apt to occur in premature births.

### THE MODIFIED GEHRUNG PESSARY IN PROLAPSUS UTERI ET VAGINÆ.

BY W. W. TURVER, M.D., PARKDALE, ONT.

I herewith introduce to the notice of the profession a pessary suitable to cases of prolapsus uteri of the second and third degrees. It is a modification of Dr. Gehrung's (St. Louis) double horse-shoe

pessary. It is composed of soft rubber, moulded on soft wire, adjustable and easily fitted to each case. It has been tested for over two years and a half in my own practice with satisfactory results. It is especially serviceable where there is much weight to be borne, as in uterine hyperplasia; also in cystocele, and in menorrhagia and metrorrhagia, associated with uterine enlargement and congestion.

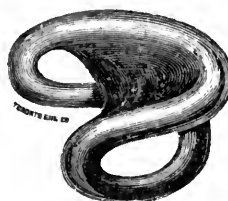


Diagram No. 1.

Diagram No. 1 shows the instrument with flexible apron springing from the upper branches.

Diagram No. 2 is a side view, showing the cervix uteri resting in the concavity, and may be more minutely described as follows:

Commencing at a point *a* which is opposite the pubis to *A* is the rounded superior portion, one and one-half inches from side to side, on which the base of the bladder rests; *A*, along the dotted line to *E*, represents the concave portion behind *a* to *A*, which receives the convex anterior surface of the cervix and fundus.

*E* represents the flexible dependent portion or apron in which the concave portion *A* to *E* terminates, so that the flexibility of *E* makes it a point of motion. That is, when the fundus uteri is pushed back by a full bladder in the arc *B* to *b*, the cervix describes a small arc forward at *E*; the varying conditions of the bladder rendering continuous pressure on any portion of the anterior surface of the uterus impossible along *A* to *E* or at *E*.

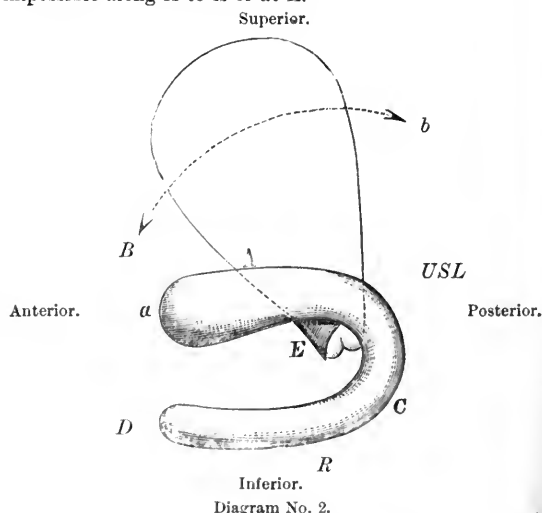


Diagram No. 2.

*C* represents the right side-branch of the pessary. The left side-branch is like it. Both branches pass backwards on each side of cervix uteri; downwards along the sacrum, each branch being immediately under each utero-sacral ligament if the rectum is distended, thence forwards, resting on the soft parts on either side of the rectum, and terminate in front by uniting in a curve at *D* immediately opposite

the ostium vaginae. C to R is the portion that straddles the rectum, resting on the soft parts on the most dependent portion of the floor of the pelvis. The curve D is the part of the pessary felt in a digital examination when *in situ*. Passing the finger over D, the full rectum can be felt between the branches at R. Raising the point of the finger to E, the cervix uteri will be felt on a level with the lower border of the flexible apron E and resting upon it. Pressing the finger laterally, the base of the bladder may be felt folding over each side of *a* to A and encroaching on the space below the upper convex portion *a* to A.

B along the dotted line to *b* represents the curve through which the fundus swings when the bladder is full or empty. The space contained by lines connecting the letters *a* B A

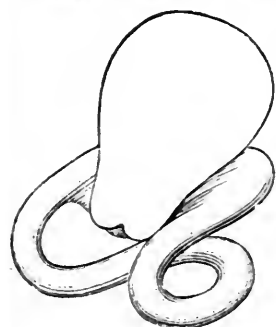


Diagram No. 3.

would indicate the position of the bladder when collapsed. U S L indicate where the utero-sacral ligaments are joined to the cervix uteri; by lifting up the uterus in the way indicated, shows how much the tension will be taken off the utero-sacral ligaments.

Diagram No. 3 shows the cervix resting on the flexible apron between the side branches.

I append a few cases in which it has been successful.

CASE I.—Mrs. C. came into my hands September 26th, 1882. I found her suffering from uterine areolar hyperplasia, chronic uterine congestion, metrorrhagia and menorrhagia. The flooding had been continuous for four months. She had miserable health for the past two years or since the birth of her last child. The case was complicated by the usual secondary or remote diseases: anæmia, impaired digestion, congestion and functional disorder of the liver, neuralgias, inability to walk, etc.

By the 1st of January, 1883, most of the symptoms were improved, except the locomotion and distressing pains resulting from prolapsus uteri. I had tried an excellent pessary recommended for such cases, viz., Dr. Gehrung's, of St. Louis. It answered very well for a day or two, but was too hard and not of sufficient breadth to carry the weight. The effect on the tissues was to form a deep depression on the anterior portion of the cervix, with tumefaction of the tissues above and below the depression.

After many experiments and failures, I succeeded in producing the pessary presented to you. As soon as it was applied, she said she seemed very

comfortable, and that she thought it would succeed. I visited her every three or four days for the next two weeks, and was gratified to find that it was entirely satisfactory. She immediately began visiting friends in the adjacent city, walking three or four miles every day without inconvenience. From the time the pessary was first applied, she remained under my care for six months, gaining strength the whole time. By recent correspondence, I learn that her health has been completely restored. After wearing it for three or four months, she stated that she never was so free from backache since she was a girl.

CASE II.—Was a patient of Dr. Woolverton's, of the city of Hamilton, who stated that it acted satisfactorily.

CASE III.—Mrs. W. came into my care in March, 1884, suffering from complete or external prolapse of the uterus of eight years' standing. Being poor and unable to pay for an operation for the purpose of diminishing the capacity of the vagina and narrowing the outlet, I concluded to try the pessary or support as I called it. She had extensive erosion of the cervix, with great difficulty in urinating, was a constant sufferer, and expected to be laid up for a month. I reduced the dislocation, by putting her on her hands and knees and using gentle pressure. I introduced Dr. Gehrung's double horse-shoe pessary, recommended by Dr. Mundé, in his work on Minor Gynæcology. It caused a ring of ulceration in three or four days. I should explain that I used it because I had none of my own or hand. I removed Dr. Gehrung's and applied my own. She has been wearing it with perfect comfort and success ever since, that is for eighteen months, and began attending to her regular duties immediately, and states that she is not conscious of wearing anything, and wishes she could have seen me eight years ago.

The following letter was addressed to me, which is conclusive of continued success:

PARKDALE, August 29th, 1884.

DEAR SIR,—It is with much pleasure I am able to say that I am so much improved. I suffered over ten years. Since I came under your treatment I have been quite a new creature. I cannot express my thankfulness too much for what you have done for me. It is now six months since I commenced wearing your support, and I attribute my restoration to its use.

Yours truly,

A. W.

I should say in explanation that she is entirely recovered from the complete prolapsus, and is now wearing the pessary for a slight cystocele. The success in this case, the patient being over sixty years of age, is due to extinction of the ovarian function, causing atrophy of the uterus when placed in the natural position. The fact of this patient wearing this instrument with comfort since March, 1884, distinctly proves that there is nothing in the material of the instrument to produce any irritation. Should there be any leucorrhœa, treat this first with glycerine and cotton tampons attached to a string, kite-tail fashion, daily. A piece of cotton saturated with glycerine or vaseline and placed between the branches for a few days, will secure toleration of the instrument at once if suitable.



The following are the directions for applying the pessary:—Place the patient on her back with the knees drawn up, turn the broad side of the pessary down, with the convexity C pointing to your left side and the side branches A and B to your right side. Take the side branch A nearest to you between your thumb and index finger of the right hand. Introduce the other side branch B until three-fourths of the pessary is introduced, then by rotating the side branch A between thumb and finger upwards, and into the right of the pelvis, the instrument is brought into its natural position, with side branches on each side of cervix, and the cervix resting on the concave flexible apron.

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### Correspondence.

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#### FILARIA SANGUINIS HOMINUM.

To the Editor of the CANADA LANCET.

SIR,—I herewith send notes of a case which fell under my notice presenting something new, (at least to me) and perhaps interesting to others. Patient, aged 58, physician; with exception of occasional attacks of lumbago has enjoyed good health until within a year ago, when he had a slight attack of hæmaturia; attacks continued at

intervals of a few months, but in no instance was the amount of blood passed of sufficient quantity to cause prostration. Health was considerably improved for some time previous to last attack. The first indication of trouble was the passing of several ounces of blood during micturition in the evening after returning from professional visits. Through the night hemorrhage increased to an alarming extent. Confrères were summoned, the usual hæmostatics applied by mouth and vesical injection. Hemorrhage continued more or less for three days, leaving patient extremely weak and blanched. Strength gradually returned under ferruginous tonics. Excruciating tenesmus was experienced at each attempt to micturate, probably caused by irritation of catheter and sound which were used to facilitate the passage of blood. Did not see patient until hemorrhage had ceased. External examination of parts revealed nothing abnormal. Urine contained a mere trace of albumen, a little mucus, and abundance of phosphates; no pus was found; sp. gr. normal. The microscope showed a few blood corpuscles, large crystals of phosphates, a few renal and bladder epithelium, and an abundance of worms, about one-seventieth of an inch in length, tapering unequally towards each extremity very much resembling the earth worm in shape; body transparent, without any definite structure. Some were coiled upon themselves others extended, but to all appearance lifeless. Previous to this no microscopic examination of the urine had been made.

Roberts speaks of this parasite, *filaria sanguinis hominum*, as being a not uncommon cause of renal hemorrhage in hot climates. The writer would be glad to receive through the "LANCET" any information regarding—*a*. The frequency of this parasite in our own country—*b*. Its importance as a cause of hæmaturia—*c*. Its natural history, including reproduction, method of operating, etc.—*d*. And most efficient method of dislodging it?

Yours, etc.,

E. A. HALL, M.D.

Glamis, Ont.

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### Reports of Societies.

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#### CANADA MEDICAL ASSOCIATION.

The eighteenth annual meeting of the Canada Medical Association was held in Chatham, Ont.,



on the 2nd and 3rd ult. There was a large number of members present and also a number of visitors and delegates from the United States.

The chair was occupied by the retiring President, Hon. Dr. Sullivan, of Kingston, who congratulated the Association on the splendid arrangements which had been made for the meeting, and the excellent programme which had been provided. He briefly referred to the rebellion in the Northwest, and the part there taken by the members of the medical profession. The care of the sick and wounded had been excellent, and the highest encomiums were pronounced on the members of the ambulance corps, the members of which displayed commendable bravery. In conclusion, he paid a high compliment to Dr. Osler, the President-elect, whose scientific attainments had given him a world-wide fame, and installed him in the chair.

The address of the President on assuming the chair was an eloquent and highly interesting sketch of the history and progress of medical education in Canada. He began by referring to the early history of the Association and its trials and difficulties. He then alluded to the Medical Acts in force in the different Provinces, and especially contrasted the Act in force in Quebec with that of Ontario, which he regarded as the most perfect piece of medical legislation yet enacted in any country. The early history of medical colleges in Canada was next alluded to. The early demise of King's College medical faculty was, in his opinion, a calamity to the profession in Canada, inasmuch as it was the only attempt ever made to establish an endowed school. He next referred to the large number of medical colleges in Canada in proportion to the number of medical students, viz., eleven schools to about nine hundred students. Of these about seven hundred were enrolled in four of the schools, leaving the balance to be divided among the remaining seven schools. The impossibility of properly equipping and sustaining these smaller schools out of the fees of the students, which is almost the only source of income, was dwelt upon. In conclusion, he alluded to the handsome endowment of McGill College, and trusted that the time would soon come when the Ontario schools would be similarly endowed, especially such chairs as physiology and pathology.

Dr. Grant, of Ottawa, proposed a vote of thanks to Dr. Osler for his interesting address. The

Association was then on motion divided into sections, and Dr. Harrison, of Selkirk, appointed chairman of the Medical section, and Dr. Edwards, of London, chairman of the Surgical section.

#### MEDICAL SECTION.

Dr. Grant read an account of an interesting case of "Aortic Aneurism," illustrated with an exhibition of the specimen. The patient had been afflicted for nearly four years before death, the treatment being complete rest with large doses of iodide of potassium. Considerable discussion followed, and great interest was manifested in the pathological exhibit.

Dr. Worthington contributed a paper on "Intermittent Cerebro-Spinal Meningitis."

Dr. Arnott read an excellent sketch on the "Sources of Malaria." Both these papers brought out an interesting discussion.

Dr. Holmes, of Chatham, presented a paper on "Puerperal Mania," and cited several cases in which it was found that laceration of the cervix was evidently the cause of the trouble. In these cases as soon as the laceration was cured recovery began.

Dr. Graham, of Toronto, presented a specimen of "Dissecting Aneurism of the Thoracic and Abdominal Aorta." The specimen was carefully examined.

Dr. Wilkins, of Montreal, read a highly interesting paper, and showed specimens—microscopical and macroscopical—illustrating the "Infectious Character of Tuberculosis."

Dr. Stewart, of Montreal, presented a paper on the curability of the "Chronic form of Infantile Paralysis" (polio-myelitis anterior chronica), which was most interesting. Galvanism was the only treatment pursued, and the internal use of medicine was not recommended. Considerable discussion followed the reading of this excellent paper.

Dr. McKeough, of Chatham, presented in very concise form notes on "The use of Pilocarpine in Puerperal Eclampsia." The conclusions arrived at were, that under certain circumstances, the use of pilocarpine was most beneficial, but that it was a remedy which experience proved should be employed with great caution.

Dr. McLean, of Ann Arbor, Mich., related a case which he considered could not be due to uræmic poisoning, but rather to reflex irritation.

Dr. Ross, of Montreal, said that attention should be paid to the irritation of the nerve centres. He

did not favor the use of pilocarpine during the convulsions, but thought that it might be used afterwards to promote reaction of the skin and kidneys. He favored the treatment of the first uræmic symptoms. He had never resorted to any means to hasten delivery in these cases. He believed that large doses of chloral hydrate were more beneficial.

Dr. Grant, of Ottawa, agreed with Dr. Ross, and thought the course recommended by Dr. Thomas, of New York, in looking carefully after the early uræmic symptoms was the best one to follow.

Dr. Bethune, of Wingham, exhibited an interesting specimen, showing a parasite removed from an abscess in the thigh.

Dr. Whiteman, of Shakespeare, Ont., read a paper on "Pelvic Peritonitis and Pelvic Abscess."

#### SURGICAL SECTION.

Dr. Carstens, of Detroit, read a paper on "Removal of Uterine Fibroids." The first case was that of a woman aged 40, in whom uterine fibroid was diagnosed within the broad ligament, and abdominal section determined on. On opening the abdomen, a large tumor was discovered within the broad ligament of right side and one small one. The ovaries were very adherent and were removed. The pedicles were ligatured and the tumors taken away. There was considerable hæmorrhage, and some twenty vessels had to be tied with silk and catgut. The patient made a good recovery.

The second case was a married woman aged 45, with enlargement of the abdomen and repeated uterine hæmorrhage. A submucous fibroid was diagnosed. The os was dilated with difficulty and a posterior incision in the cervix was made, the tumor enucleated and removed with an écraseur. The wound in the cervix was stitched and the patient was able to sit up in six days. Dr. Carstens insisted on the necessity of abdominal section in many of these cases.

Dr. Gardner preferred bilateral incision of the cervix in such cases, and does not sew up the wounds. He recommended irrigation of the uterus with two parallel tubes every two hours after operation.

Dr. Fulton, of Toronto, read a paper on "Subperiosteal Amputation," and cited a number of cases in which he had practised this method of amputation during the past six years, both in hos-

pital and private practice, with most satisfactory results. This method was first advocated by Walther, seventy years ago, but was put into practice by Ollier in 1859. With the introduction of antiseptic surgery the operation was revived and now promises to take a prominent place amongst surgical operations. Dr. Fulton described the operation and stated its advantages, the chief of which are, 1st. The cut end of the bone is covered by the tissue physiologically suited to protect it. 2nd. The bone does not become adherent to the end of the stump. 3rd. The medullary canal is closed in rapidly and effectually, by new bone. 4th. Danger from the spread of inflammation or suppuration to the bone is guarded against. Experiments on animals have shown that a flap of periosteum rapidly closes the medullary canal and prevents the occurrence of osteo-myelitis. The operation is especially adapted to cases in which the medullary canal is in a soft and unhealthy condition, such as is frequently met with in amputations for diseased bones and joints. The reader of the paper was strongly convinced of the utility and value of this method of amputation.

Dr. McGraw, of Detroit, remarked that Langenbeck had performed subperiosteal amputation in 1862, but, as the case did not turn out very well, he did not continue to adopt this procedure in his amputations. Dr. McGraw believed that it is most important in amputations to draw together similar tissues. He strongly approved of the subperiosteal method of amputating.

Dr. Donald Maclean, of Detroit, said that many of the so-called advances of modern surgery are of very questionable benefit, but the one recommended by the reader of the paper seemed to have much to recommend it. It is the duty of the surgeon to pay more attention to the details, not only of the operation, but the after-treatment, and to everything to avoid unpleasant after-results.

Dr. Davidson, of Toronto, thought the operation should be more practised than it is now. He thought that in performing the operation the periosteum should be reflected back before the bone is cut, thus necessitating only one division of the bone.

Drs. Samson, of Blenheim, and Shepherd, of Montreal, also took part in the discussion.

Dr. Shepherd, of Montreal, read a paper on "Ligature of the Linguals in Excision of the

Tongue," in which he maintained that the operation of excision of the tongue, with preliminary ligature of the linguals, facilitates the removal without adding much to the risk of the operation. He considered that in excision of the tongue it is as important to excise diseased glands in the neck as it is to remove diseased axillary glands in extirpation of the breast, and the incisions for ligation of the linguals facilitate their discovery and removal. He recommended the use of iodoform gauze dressings in these operations.

Dr. Maclean, of Detroit, said that when there was no involvement of the glands of the neck, he preferred removing the tongue with the *écraseur*. The great danger of all the operations for the removal of the tongue is septic disease of the lungs.

Dr. Grant, of Ottawa, intended, when a proper case presented itself, to practise the operation. He related a case of deep-seated abscess of the tongue which had lately been sent to him as one of malignant disease.

Dr. Atherton, of Toronto, did not think ligature of the linguals a very simple operation. He advocated the performance of preliminary tracheotomy in excision of the tongue, as by this means the wound is kept aseptic and septic involvement of the lungs prevented.

Dr. W. Gardner, of Montreal, read the report of a case of "Double Uterus, with Atresia and Hæmatometra of left Chamber." The presence of fluid was diagnosed, and on opening into the chamber, fifty ounces of tarry blood escaped. The cavity was washed out by double drainage tubes. The patient did well for a week, but the temperature then rose and she died of peritonitis, nineteen days after the operation. The autopsy showed a bi-cornate uterus, the left portion containing tarry fluid. The left Fallopian tube was sacculated and contained the same tarry fluid, and other smaller hæmatoceles were found in the broad ligament: the left ovary could not be distinguished. These cases are rare and the prognosis is grave. Dr. Gardner regretted that he had not opened the abdomen, removed the tube and ovary and drained the cavity.

Dr. Roswell Park, of Buffalo, reported a case of "Extirpation of the Larynx for Malignant Disease," and exhibited a model of an artificial larynx after Gussenbauer's pattern. The case was that of a man, aged 64, who suffered from papilloma-

tous disease of the larynx which had undergone cancerous degeneration. The operation was performed on the 28th of last June. The epiglottis was left behind, and the first ring of the trachea removed with the larynx. The wound was packed with iodoform gauze and healed rapidly. The patient was fed for the first few weeks by a tube passed through the wound. He is now wearing an artificial larynx, and can swallow well and talk with ease. The removed larynx was exhibited and showed the malignant disease completely blocking up the rima glottidis. Dr. Park said that this was the 95th extirpation of the larynx, and the third on this Continent.

Dr. Atherton, of Toronto, then read a paper on "Laparotomy for Uterine Myomata," citing two cases. In the first case the tumor was of considerable size and intra-ligamentous. The pedicle was transected with pins, compressed with a rubber bandage, removed by a wedged-shaped incision, and the vessels ligatured. The two edges of the stump were sewed together and the abdominal wound closed and drained. The patient recovered. The second case was a young lady, aged thirty-five who had had an enlargement of the abdomen for some years, with recurrent hemorrhages. On opening the abdomen a large tumor was found filling up the posterior part of the pelvis and firmly adherent; the adhesions were separated with the finger, and the tumor removed as in the former case, but the adhesions were extensive and troublesome. A drainage tube was used and the abdomen closed. The patient died on the fifth day.

Dr. Gardner, of Montreal, said that the suggestion of Dr. Atherton to close the cervix by a preliminary operation was a good one.

Dr. Eccles, of London, said that the removal of part of the uterus with a myoma produced a great shock, and mentioned a case in which he had removed a fibroid by the wire *écraseur* in a woman aged 59. Suppuration followed but she recovered.

Dr. Jenks, of Detroit, never had a case of recovery where there were extensive adhesions in Douglas's cul-de-sac. In all abdominal operations he advised the bowels to be thoroughly emptied to prevent tympanites, and recommended the use of ox-gall as a laxative in ten to twenty grain doses.

Dr. Fulton, of Toronto, also endorsed the view that clearing out the contents of the bowels pre-

vented tympanites. He thought that the method of drainage into the vagina had not been sufficiently tried, and believed it a most scientific and rational procedure.

Dr. Rutherford, of Chatham, read a paper on "Suprapubic Urination." He described the suprapubic tapping with trocar, and the introduction of a soft catheter. He cited four cases, where the operation had been performed for retention from enlarged prostate. In one case the patient had been for four and a half years, urinating through the suprapubic opening. In another the patient, after urinating for some time through the artificial opening, was able afterwards to pass his water by the natural passage.

Dr. Burt, of Paris, Ontario, read a paper on "Internal Urethrotomy." He used Maisonneuve's instrument, and said that he had never seen any evil results follow the operation. He had frequently operated most successfully in very severe cases and with permanent relief. The operation is easy of performance and safe, and in most cases followed by a permanent cure.

The following officers were elected for the ensuing year: President, Dr. Holmes, Chatham; Vice-Presidents—for Ontario, Dr. Sloan, Blyth; for Quebec, Dr. Colin Sewell, Quebec; for New Brunswick, Dr. Earle, St. Johns; for Nova Scotia, Dr. Wickwire, Halifax; for Manitoba, Dr. Brett, Winnipeg; General Secretary, Dr. J. Stewart, Montreal; Treasurer, Dr. Sheard, Toronto; Local Secretaries—for Ontario, Dr. Wishart, London; for Quebec, Dr. Bell, Montreal; for New Brunswick, Dr. Lunam, Campbellton; for Nova Scotia, Dr. Almon, Halifax; for Manitoba, Dr. Good, Winnipeg. Quebec was chosen as the next place of meeting.

The Banquet given by the profession of Chatham on the evening of the first day, was a great success. The attendance was large and the speeches unusually good. The greatest credit is due to the physicians of Chatham and vicinity for their efforts to make the meeting what really was a great success.

#### NEW BRUNSWICK MEDICAL SOCIETY.

The fifth annual meeting of the New Brunswick Medical Society, was held in Fredericton, on the 21st of July, Dr. Walker of St. John, President, in the chair, Dr. Musgrove, Secretary. A large number of members were present, also several dele-

gates from the State of Maine, U.S. The President delivered an able and interesting address which was well received.

A communication was received from the Women's Christian Temperance Union, asking the Medical Society to co-operate with the Union in their efforts to prevent the drinking of intoxicating liquors, even as medicine when such medicines were not absolutely necessary.

Drs. Jonah, Coulthard, Steeves, Bruce and James Christie were appointed a committee to consider the communication.

Dr. Moore, of the Tariff Committee, reported that the tariff for applying a plaster jacket be fixed at from \$10 to \$50. Adopted.

Dr. Steeves reported from the medical council that the charge reported against Dr. George McKay, of Fredericton Junction, for passing under an assumed name was proved, but nothing was proved to disqualify him for membership of the society. Dr. Bayard had resigned as a member of the council and Dr. Thomas Walker had been added. The report was received and adopted.

The following officers were elected for the ensuing year:—President—Dr. P. R. Moore, Sackville; Vice-presidents—Dr. Coulthard, Fredericton, and Dr. Thorne, Havelock; Secretary—Dr. Musgrove, Carleton; Corresponding Secretary—Dr. Bruce, St. John; Treasurer—Dr. D. E. Berryman, St. John; Trustees—Drs. Barker, G. H. Coburn and Wm. Christie; Member of Council, vice Dr. Vail—Dr. G. M. Duncan, Bathurst.

Dr. Walker read Dr. Daniel's paper on "The Septic Influence of the Poison of Diphtheria in the Puerperal State," and Dr. Jonah read a paper on "The Artificial Feeding of Children." The latter paper caused a discussion in which several gentlemen took part.

#### SECOND DAY.

The association met at 10 A.M., Drs. Botsford, P. R. Moore, T. C. Brown and Musgrove, were appointed delegates to the Maine Medical Association.

Dr. Smith, of Woodstock, read an excellent paper on the "Causes and Treatment of Amenorrhœa."

Dr. D. R. Moore, of Stanley, read a paper on "New Remedies" which was fully discussed.

Dr. Jonah reported from the committee on the communication from the W. C. T. Union to the effect that the profession always have

endorsed the principles of temperance, while they fully recognize the value of stimulants as remedial agents, and they sympathize with the efforts of all temperance organizations to suppress the vice of intemperance, but the wording and sentiments of the resolutions presented us, are such that we recommend that the communication be placed on the table without discussion. The report was adopted.

Dr. Bruce read a very able paper on "A Clinical Study of Conjunctival Disease," which was discussed very fully.

Dr. Musgrove read a paper on "A Remarkable Case of Hysterical Contraction." He was followed by Dr. James Christie on "The Treatment of Wounds."

Dr. Sprague then read a paper on "The Causes and Treatment of Dysmenorrhœa."

Dr. Coulthard read notes of a number of cases of "Puerperal Convulsions."

The papers were discussed at considerable length and many interesting points brought out. After formal votes of thanks the meeting adjourned to meet next year in St. John, N. B. A conversation took place in the evening, and was a great success.

### Selected Articles.

#### TUMOR OF THE CORPORA QUADRIGEMINA.

The case recorded by Dr. Carnazzi, *Rivista Veneta di Scienze Mediche*, is of especial interest, from the light it throws on the functions of the parts involved, and from the fact that the opinion formed during the patient's life as to the nature and seat of the tumor was confirmed after death.

The patient, a man named Colombi, age 31, had good health till the middle of last July. Then he began to suffer from short sharp attacks of frontal headache, at intervals of several days. The attacks gradually increased in frequency, in severity, and in duration. Then they were accompanied by giddiness and vomiting. The mental faculties, hitherto unaffected, were disturbed only during the attacks. Silly acts were performed, ideation and perception were clouded, and memory was weakened or suspended. In the intervals between the paroxysms, the patient appeared quite well in every way. This alternation continued for two months, when the patient was taken into hospital in the middle of September.

At this time he was slow in expressing himself, and he had a slightly stupid look, but there was no

lack of harmony amongst the features. The senses, sight, hearing, smell, and taste, were normal. The right pupil was somewhat mydriatic; but both reacted to light. There was no facial spasm or paralysis, and the tongue was protruded without deviation. While the patient was in bed, there was no functional alteration either in the trunk or in the extremities. When he was made to get up and walk, his gait was staggering. In the upper limb there was not any disturbance of function. There were no anæsthetic or hyperæsthetic points. Excretions and secretions were normal. The pulse and respiration were normal, and there was no fever. The patient complained only of continuous weight in the head, and of headaches recurring every ten or twelve hours, followed by vomiting or attempts at vomiting. This was the condition of Colombi when he was received into hospital, two months after the first symptoms had shown themselves.

Some days after this he was seized with a slight convulsive attack, rolling over on the left axis of the body, and remaining unconscious for about ten minutes. When he came to, he was confused in mind. Vision was obscured on the right side; the right pupil was mydriatic, and the iris inert. The left eye remained normal. During the attack the radial pulse fell as low as forty-four beats a minute, and remained at this point for some hours. These attacks recurred at first at intervals of four or six days; then every twenty-four hours, and lasting two or three hours at a time. The pulse on these occasions fell to forty or forty-two beats; and the respirations became stertorous.

With the progress of the case other symptoms appeared. Strabismus occurred, at first during sleep, then in waking hours; the right eye was turned upwards, the left downwards. The head and trunk were permanently drawn backwards to the right; and lower limbs contracted. The sight of the right eye gradually diminished to absolute blindness, and the left eye followed the same course later on. In the last fifteen days of the patient's life rapidly advancing bed-sores and a sacral abscess showed themselves. On November 13 the patient died, greatly emaciated.

Professor Lussana, who saw the case, diagnosed a cystic tumor of the mesocephalon. The author, after repeated examinations, was able still further to localise the disease as a cystic tumor in the corpora quadrigemina, especially on the left side.

The post mortem examination revealed a tumor about the size of a hen's egg, situated upon the corpora quadrigemina, which it had rendered atrophic. Hardly a trace was left of the divisions between its parts. The tumor was in contact with and slightly buried in the anterior-superior border of the cerebellum, where there was a slight and superficial softening corresponding to the origin of the transverse and superior peduncles.

The softening extended about a centimetre on the right side, and a half centimetre on the left. The thickening and compressed peduncles did not present any change in texture. The tumor was a round-celled sarcomatous cyst containing about forty grammes of a creamy whitish fluid, probably mucoid degeneration. In the lateral ventricles were found several small hydatid tumors attached to the choroid plexus; four in the right ventricle, three in the left.—*London. Med. Journal.*

**TREATMENT OF ACUTE RHEUMATISM.**—At the annual meeting of the British Medical Association, Dr. PAVY, in discussing the treatment of acute rheumatism, said that this was one of those subjects upon which the hospital physician might specially feel himself entitled to speak. He had formed a very strong opinion with regard to the salicylate treatment. His experience now contrasted in the strongest possible manner with his experience before the treatment was introduced. Students of the present day had no opportunity of seeing in the wards the disease run its natural course, with all its urgency and severity of symptoms, as they had formerly, when it might be said there was no treatment known that produced any decided impression upon it. To use the salicylate treatment to effect, the agent must be given largely. The usual plan at Guy's Hospital was to give twenty grains of salicylate of soda every two hours for the first twenty-four, thirty-six, or forty-eight hours. By this time the pain was generally removed from the joints, and the temperature brought down, and the patient altogether placed in an easy condition. The frequency of the dose might then be reduced to every three hours, and later to every four and six hours. What he considered of the greatest importance was that, notwithstanding the complete subsidence of the disease, the treatment in a case that was severe should be continued for at least twelve or fourteen days. He sometimes met with a certain amount of discontent in having this carried out. The patient often could not be brought to understand the necessity of being kept in bed, and upon the milk and farinaceous diet to which he was restricted for at least the time named, and would press for the restrictions imposed to be removed. His experience led him to conclude that the salicylate treatment, in subduing the symptoms as it did, simply controlled the manifestations of the disease, without absolutely removing or eradicating that which gave rise to the manifestations. Time was required for this to subside; and if, during this time, the treatment, or that which kept the condition under control was removed, immediately it manifested itself by a return of the symptoms. This was the view that forced itself upon him from what he had seen. It accounted for many of the relapses that occurred,

and explained the necessity of keeping the patient under treatment for a definite time, however speedily the disease might appear to have yielded. The treatment did not influence the complication as it did the disease itself. With the disease subdued at once by this treatment, the complications were not likely to arise as under other circumstances; but, if a patient were admitted with pericarditis or endocarditis, this was not influenced in any marked manner by the treatment. Hyperpyrexia was not controlled by the treatment; if it were, the management of this grave condition would be much more easy than it was. The more acute and general the case of rheumatism, the better he considered it adapted for the salicylate treatment. Indeed, in chronic or subacute cases, or where only one or two joints were attacked, he had not found any decided benefit derivable from it. Sometimes the salicylate produced toxic effects, which constituted a barrier to its further administration to the extent required. Directly these toxic effects showed themselves, his plan was to take off the salicylate and administer salicine in a similar dose. This, he found answered what was wanted. He did not begin with salicine in the first instance, as, rightly or wrongly, he was under the impression that the salicylate was the more powerful anti-rheumatic agent of the two.—*British Medical Journal*, August 22, 1885.

**IMPORTANCE OF INQUIRING INTO THE CONDITION OF THE BLADDER.**—Mr. Lund, Professor of Surgery in the Victoria University, in lecturing, spoke of some genito-urinary troubles. Referring to a topic which cannot be too often brought before practitioners, viz., retention of urine, Mr. Lund mentioned three striking cases. One was that of a young lady in whose case he was called in consultation to perform paracentesis; retention of urine was found. Another was that of an elderly man, with what was supposed to be a pelvic tumor pressing on the rectum, and causing tenesmus and difficulty in defecation. A quart of urine was drawn off, and the urgent symptoms soon disappeared. Another case was that of an elderly gentleman, who was suddenly seized with giddiness and rigors while at work in his office. Profuse perspiration came on. He went to bed and vomited. The abdomen was distended, and hernia was suspected. Mr. Lund catheterized and removed five pints of urine. Mr. Lund's second case reminded me of one recorded in Dr. Mathews Duncan's "Clinical Lectures." Dr. Duncan was sent for to pay a "satisfaction" visit to a patient said to be dying with malignant disease of the rectum. He was told that the growth could be felt in the iliac region, so far had it advanced. On examination the case was found to be one of enormous fecal accumulation in the bowel. On "digging" this out the symptoms disappeared.

When puncture of the bladder is required, Mr. Lund prefers the suprapubic method. "It is," he says, "cleaner, and an instrument can more easily be retained."

In infants, circumcision should always be performed, he thinks, when the prepuce "balloons out" during micturition. Otherwise the straining tends to cause inguinal hernia. When a hernia has been produced Mr. Lund prefers the "worsted truss."

A case of vesical calculus was described in which the symptoms of stone were marked by enlargement of the prostate. The stone was kept from pressure on the collapse of the bladder, and perhaps kept in one place by its shape, it having become moulded to the neck of the bladder above the base of the prostate. Another case was mentioned in which the converse occurred, viz., a stricture far back in the membranous urethra caused such dilatation of the prostatic portion as to set up symptoms of calculus, which subsided on division of the stricture. An interesting case was referred to by the lecturer, in which a "click" was heard on introducing a metallic catheter into a woman's bladder, after a sound had failed in producing any. It was afterward found that this only occurred when the stream of urine was stopped by placing the finger on the mouth of the catheter. The bladder possessed great expulsive power, and while the urine flowed freely there was no sound. —(London Letter.)—*N. Y. Med. Record*.—July 18th.

**THE FUNCTION OF THE THYROID GLAND.**—Most works on physiology pass over the thyroid gland with a very superficial mention. It is said to exercise some part of importance in fetal life, no one knows what. In extra-fetal life it is said to partially atrophy, and to be merely a useless organ to the adult—rather worse than useless as in goitre it becomes inconvenient, and sometimes dangerous.

This shows how little we know about human physiology. Recent researches have shown that the thyroid gland has an intimate and all-important relation to the highest functions of man, those of his brain. This fact was first developed by the extirpation of the gland in goitre, a proceeding which, according to the received views, ought to be wholly indifferent to the economy. Such is far from the case. After the total extirpation of the gland, the subjects steadily lose their mental vigor; the features become heavy; the speech slow and dull; the muscular system weakens, and the skin turns rough, thick, and hard; in short, a condition gradually supervenes strikingly like that called by Charcot *myxœdema*, or the pachydermatic cachexia. They become *cretins*.

If ever so little of the gland remains, it is sufficient to prevent these changes; but its complete

removal surely entails them. Experiments on dogs and cats yield similar results. The animals do not long survive, but are attacked with convulsions, somnolence and paralysis, which prove fatal.

Two theories have been advanced to explain these changes. One is that of Leibermeister, who maintains that the thyroid gland is the regulatory organ of the encephalic circulation, and that its abstraction throws this into chronic disorder. The other is that of Prof. Bruns, of Tübingen. He believes that the thyroid is either a depuratory gland which excretes certain substances poisonous to the nervous system, or that it fabricates certain substances indispensable to nervous vigor—which of the two he is uncertain.

The very important practical conclusion remains uncontested, that in all operations for goitre, a small portion of the gland should be allowed to remain.—*Med. and Surg. Reporter*.

**TO PREPARE SURGICAL SPONGES.**—The following is Mr. Lawson Tait's method of preparing the sponges, and but one person is trusted to do this: New sponges are first put into a large quantity of water with sufficient muriatic acid to make the water taste disagreeably acid. They remain in this mixture until all effervescence has ceased and all the chalk is removed. For this purpose it may be necessary to renew the acid several times. The sponges are afterward carefully and thoroughly washed, to make them as clean as possible and free from every rough particle. After being used at an operation, they are first washed free from blood, and then put in a deep jar and covered with soda and water (one pound of soda to twelve sponges). They are left in this about twenty-four hours (or longer if the sponges are very dirty), and then they are washed perfectly free from every trace of soda. This takes several hours' hard work, using hot water, squeezing the sponges in and out of the water and changing the water constantly. Leaving them to soak for a few hours in very hot water greatly assists in the cleansing. When quite clean, they are put in a jar of fresh water containing about one per cent. of carbolic acid, and after being in this way for twenty-four hours they are squeezed dry and tied up in a white cotton bag, in which they are left hanging from the kitchen ceiling (being the driest place in the house) till they are wanted.—*American Journal of Obstetrics*.

**THE TREATMENT OF WHOOPING COUGH.**—In his summary of treatment, in a clinical lecture delivered at the Philadelphia Hospital (*Medical News*), Dr. John M. Keating emphasizes the value of the steam spray and of the atomization medicated solutions, among which he ascribes value to Dobell's solution, eucalyptol, and thymol. With the bichloride he advises caution. Corrosive sublimate, which is now used for almost everything,



he says, has also been applied here in the form of the spray. He remarks that it is a dangerous drug to put in the hands of an inexperienced person, and, as we have so many other useful remedies for this affection, he thinks it is wise to avoid the use of corrosive sublimate. He has used listerine extensively with good results in the treatment of whooping cough. He employs it in the strength of one drachm to two ounces of water, with an ordinary hand-atomizer, directs the nurse to apply it twelve or more times a day, and finds that little children, even babies, do not object to it. He adds to it tincture of belladonna, potassium carbonate, or ammonia bromide, as the case may demand. Chloride of ammonia he also finds of great service in the form of a spray.—*New York Med. Journal*.

**THE TREATMENT OF INTRA-UTERINE DISEASE.**—Three papers on this subject (*Brit. Med. Jour.*, Nov. 29, 1855) were read before the Obstetric Section of the British Medical Association, at the fifty-second annual meeting.

Dr. Lombe Athill opened the discussion by a paper in which, after referring to the prejudice which formerly existed against treating the uterine mucous membrane as similar surfaces in other situations are treated, a prejudice which is fast disappearing, the author takes up the consideration of the best method of making such applications as may be necessary. He briefly sums up the conditions which demand such treatment, thus: "all affections of local origin giving rise to profuse menstruation, metrorrhagia, or uterine catarrh, or in which hyperæsthesia of the nerves distributed over the inner surface of the uterus exist." Polypi and other tumors he would exclude, but certain forms of recurrent growths, and of malignant diseases, are to be included. He specifies "local origin" in order to guard against conditions dependent upon affections of the tubes and ovaries being treated in this manner.

The agents he would employ are borax, iodine, carbolic acid, iodized phenol, nitric acid, iodoform, and solid nitrate of silver. Of these remedies, the author finds he uses carbolic acid in nearly seventy per cent. of cases requiring intra-uterine medication, iodized phenol in about fifteen per cent., and nitric acid in three per cent. Borax in the form of a saturated solution in glycerine he uses very occasionally in exceedingly mild forms of catarrh, which have nearly yielded to harsher remedies. Iodine, either in form of tincture or liniment, he considers very inert, as probably very little is absorbed, and its action is mainly caustic. Carbolic acid is the most useful agent, both for curing catarrhs and relieving pain. It should be applied every three or four days, and its use continued some weeks. Iodized phenol, which is iodine dissolved in carbolic acid, one part to three or four,

is of great value in certain cases, especially of hæmorrhage. Nitric acid is the most active of the agents. It does not cause much pain, but the cervical canal should always be protected by a tube of vulcanite or platinum. Iodoform is used in the form of slender crayons in some cases of dysmenorrhœa, and of fetid discharge from the uterus. The solid nitrate of silver as recommended by Sir James Simpson for menorrhagia, depending on subinvolution of the uterus, does not act very satisfactorily, and the author rarely uses it.

All of the agents except iodoform and solid nitrate of silver are used by winding a bit of cotton on a flexible probe, and passing it into the cavity of the uterus. By using dry cotton first, and so removing the mucus, the application will reach the uterine mucous membrane more thoroughly.

There are four conditions where it is necessary to adopt other means: (1) When the mucous membrane is so vascular that the introduction of the probes is followed by hæmorrhage. (2) When the cavity is of large size. (3) When hæmorrhage occurs as the result of vascular growths. (4) When epithelioma affects the cavity of the uterus. For all these conditions the author has been in the habit of dilating, curetting, and applying nitric acid with very good results except in cases of epithelioma. In four cases, the details of which he gives in full, where there was a vascular growth inside the uterus, and where nitric acid failed to control the hæmorrhage, he was induced to try injections of iodized phenol, diluted with an equal part of alcohol, a method which was successful in restraining the hæmorrhage, and prolonging the patients' lives.

Dr. Thomas More Madden, in his paper on the same subject, after a short historical introduction, speaks of the methods of dilating the uterine canal, as by graduated series of dilators, where the tissues are lax, or by tents, especially laminaria, when there is more rigidity. Oftentimes to get the best effect of the agent applied, even when there is no abnormal growth, a moderate curetting beforehand is of advantage. The majority of cases calling for intra-uterine medication, are, according to Dr. Madden, those of what we should call areolar hyperplasia and subinvolution of the uterus. For this treatment he recommends fuming nitric acid applied with the necessary precautions, after thorough dilatation of the canal. Milder applications of carbolic acid, iodoform, and tincture of iodine are recommended later.

For the treatment of tumors within the cavity of the uterus, if submucous or pedunculated, he advises enucleation or écrasement. Within the past few years he has removed forty-two such tumors with thirty-nine recoveries and three deaths. He ends with urging the importance of general as well as local treatment in these cases.

Dr. John W. Byers emphasizes the importance

of the rôle which general endometritis plays in the production of the various changes in the mucous membrane and the resulting symptoms which call for intra-uterine medication. Of the four methods, by injections, by the introduction of remedies in the solid form, by ointments, and by swabbing or painting the remedies over the interior of the uterus, he prefers the last. His testimony as to the relative value of the different solutions recommended, and as to the use of the curette, agrees with that expressed in the other papers.—*Boston Med. and Surg. Journal*.

**BORO-GLYCERIDE IN SKIN DISEASES.**—Says Chas. Roberts, F.R.C.S., *Brit. Med. Journal*, as I do not remember to have seen any recommendation of boro-glyceride in the treatment of skin diseases, and as I have recently stumbled upon it and found it a most useful remedy for psoriasis and other scaly forms, and especially in allaying the itching which accompanies many forms of skin affections, I venture to call the attention of the profession to its use. A small sample of the preparation sent by the manufacturers happened to reach me while I was treating a very chronic and irritable case of psoriasis with little benefit from the usual remedies, and this coincidence led me to the use of the boro-glyceride as a local remedy with very gratifying results, and I have since employed it with gratifying results in other cases. The action of the drug is certainly not due to the glycerine alone, as I had already tried that substance without permanent benefit. I believe that I was the first or one of the first, to call attention to the use of liquor carbonis detergens as a local remedy for chronic eczema, and I was led to employ it in the same casual manner. While engaged in making some comparative experiments many years ago at the York Hospital on antiseptics and disinfectants, a sample of the liquor carbonis was sent to me by the manufacturers, and I immediately extended its use to the treatment of eczema, and especially to the chronic eczematous ulcers of the legs common in the out-patient room of the provincial hospitals. Many patients object to the use of the liquor carbonis on account of its pungent tarry smell; but no objection of this kind can be advanced against the boro-glyceride, as it is free from scent. It has, however, the drawback of being sticky, like pure glycerine, while it has, on the other hand, the advantage over many other remedies, of not being poisonous.

**TREATMENT OF GENERAL GRANT'S CASE.**—Early in the disease, specific treatment was given in order to eliminate any possible error of diagnosis in that direction, although there were no clinical indications for specific treatment, and only negative results followed. Iodoform was used as a local application to the ulcers, and gargles com-

posed of salt and water, diluted carbolic acid, solutions of permanganate of potash and yeast. A four-per-cent solution of cocaine was occasionally applied to the painful parts with happy results, but it was never employed to any such excess as is generally believed by the public, nor were there any bad effects manifested from its administration at any time. Red clover was given quite constantly, but it produced no effect upon the local disease. It only acted as a laxative, and was continued as being the least harmful of medicines of this sort for continuous use. A small quantity of morphia daily was injected hypodermically. His food consisted of beef extracts, milk, eggs and farinaceous materials, always in liquid form. The appetite of the patient was consulted in determining the choice of food whenever any craving existed. In March an acute inflammatory process was engrafted upon the original disease, and an exudation was thrown out which partook largely of a diphtheritic nature. To this complication was due the great depression at this time. The accumulation of mucus causing the distressing, choking spells, was chiefly owing to this engrafted inflammation and exudation. Digitalis and coca were given as heart stimulants, but the weakened condition continued, and early on the morning of April 1st, heart failure seemed imminent. The members of the family expected that every moment would be his last, and the farewells were said. Finally hypodermic injections of brandy were administered, reviving the patient, and bridging him over a threatened collapse. One week after this the exudation became detached, and the patient rallied and became much better—not of the cancer, but of the complication. As we are painfully aware, the cancer pursued its destructive course until death occurred July 23rd, nine months only after its beginning.—*Med. World*.

**THE BOY AND THE BONE-SETTER.**—Speaking of bone-setters recalls a good story which occurred in the North of Scotland, where one of them had risen to great fame and no small fortune by his skill. A country lad residing a few miles off had got his leg hurt at one of the local factories, and had been treated for some time by the local medical man without any good result. His mother, who had great faith in the neighboring bone-setter, wanted the lad to go to him which he declined, preferring, as he said the "regular faculty." Eventually, however, his mother's persuasions prevailed, and he agreed to allow himself to be taken to see Daniel R—, the bone-setter. A bed for the invalid was extemporized on a cart, and, accompanied by his anxious mother, he was, after a rather painful journey, taken to the town where the bone-setter resided. The leg was duly examined, and it was found necessary to haul it very severely in order, as the bone-setter said, "to get the bone in." The

lad was liberal with his screams while this was going on, but eventually the bone was "got in" and he was told to go home, and in a few days he would be all right and fit for his work. He was lifted upon the cart again, and, with his mother seated beside him, set off for their home. "Didn't Danny do the thing well?" said the joyous old lady. "Yes, he did, mother," said the lad, "but I was na sic a fool as to gie him the sair leg!" The "reg'lar faculty" will, we have no doubt, appreciate the story.—*Whitehall Review*.

**OPERATION FOR INTESTINAL OBSTRUCTION.**—Mr. J. Greig Smith gives the following concise rules for the operation of laparotomy in intestinal obstruction:

1. Make the incision in the middle line below the umbilicus.
2. Fix upon the most dilated or the most congested part of the bowel that lies near the surface, and follow it with the fingers, as a guide to the seat of obstruction.
3. If this fail, insert the hand, and carry it successively to the cæcum, the umbilicus and the promontory of the sacrum.
4. If this again fail, draw the intestine out of the wound, carefully covering it, until increase of distension or congestion, or both in one of the coils, gives an indication that the stricture lies near.
5. If there be considerable distension of the intestines, evacuate their contents by incision and suture the wound. Never consider an operation for intestinal obstruction inside the abdomen finished until the bowels are relieved from over-distension.
6. Be expeditious, for such cases suffer seriously from shock. The whole operation ought to be concluded in half an hour.—*Brit. Med. Jour.*, June 13, 1885.

**CHOLERA MORBUS.**—Professor Da Costa says the quickest way of stopping the vomiting and purging of cholera morbus is to give a hypodermic injection of morphia, gr.  $\frac{1}{2}$ , and atropia, gr.  $\frac{1}{100}$ , to be repeated in half an hour if necessary. Carbolic acid in half-drop doses will be found useful at the same time. It should be given in mint water every twenty minutes, until the stomach becomes less irritable. In obstinate cases, where the symptoms have lessened in severity, but manifest a disposition to linger, the best results will be obtained from the administration of calomel, gr.  $\frac{1}{2}$ , soda bicarb., gr. iij. every half-hour. For the cramps in the stomach and legs, Professor Da Costa recommends friction, with ginger, capsicum, whiskey, or a liniment composed of chloral 1 part, soap liniment 3 parts. Instantaneous relief can always be secured by the use of chloral hypodermically.—*Med. Bulletin*, July.

**HYDROCELE IN THE MALE.**—The *Virginia Medical Monthly* for July contains an interesting clinical lecture on Hydrocele in the Male by Dr. Fred. S. Dennis, Professor of Surgery in Bellevue Hospital Medical College, New York. The most noticeable points in it are Dr. Dennis' argument in favor of always trying the palliative treatment by paracentesis first, on the ground not only of occasional inconvenient results from the radical operation, but of the frequency of cure after simple tapping. Dr. Dennis has seen many cases permanently cured by this procedure. In the first series of 100 cases operated on by Dr. Dennis, he was surprised to find 25 per cent. cured by a single tapping. Another point of interest in Dr. Dennis' paper is that he shows, on the good authority of Professor Welch, that in some hydroceles the fluid contains, in addition to albumen and cholesterine, indigo-blue. This is a new observation by Dr. Welch. The indigo-blue is supposed to be produced by the decomposition of indican, Dr. Dennis' favorite operation for radical cure is the excision of a piece of the sac, or simple incision into the sac, evacuation of the contents, and stitching the tunica vaginalis and skin together, "*under strict antiseptic precautions.*"—*Lancet*.

**NO MORE FORTUNES IN PILLS.**—According to a Philadelphia druggist, within the past three or four years the price of patent medicines has steadily declined, and fortunes are not made so rapidly as formerly out of pills and bitters. This cutting in rates began in Philadelphia, and has gradually extended all over the country. On some medicines the cut was as high as fifty per cent., and the reduction on all patent medicines will average over twenty-five per cent. Formerly a good patent medicine that was properly handled and liberally advertised would make a fortune for its proprietor in a few years. Remedies warranted to cure all the ills that flesh is heir to, and greedily purchased by a credulous public, sold readily at retail at one dollar per bottle and cost little to manufacture. They can now be bought for fifty cents, and the bottom price has not yet been reached. There is no longer any money in patent medicines, either for the druggists or the manufacturers. Prices have been cut so that the margin of profit hardly pays dealers for handling them, and the proprietors complain that the reduction has affected their business also. They claim that their medicines cost to manufacture and put on the market nearly what they are obliged to sell for to the jobbers. There has been a great revolution in the patent medicine business, and no one can tell where it will end.—*Medical Record*.

**TREATMENT OF NÆVUS BY SODIUM ETHYLATE.**—Samuel Welch, M.R.C.S., gives the following in the *Brit. Med. Journal*:—For some months past

ethylate of sodium has been extensively employed by me in the treatment of cases of nævus occurring in children, and up to the present I have every reason to be satisfied with its use. I paint over the nævus two coatings of sodium ethylate on two consecutive days, taking care to protect the skin before the application, and in all instances of superficial nævi thus treated, have found them cured on the separation of the scab. Those cases affecting the subcutaneous tissues generally require a second, or in some cases even a third repetition of the remedy. It seems to leave less scar than nitric acid, to cause less pain to the child, and of all applications is the one least dreaded by the mother.

**TREATMENT OF VENEREAL DISEASES IN NEW YORK.**—A correspondent of the *Can. Med. Record*, writing from New York, says: We will now pass into the venereal ward, not, however, so much for the purpose of learning the signs, symptoms and pathology of venereal diseases (for there has been little change in the teaching on those points), as to acquire a knowledge of the latest and most approved methods of treatment. As far as I can learn, more importance is attached to irrigation of the urethra than to any other remedy for gonorrhœa. A bottle, containing a gallon of warm water, is placed near and slightly above the patient. A catheter (about No. 6 in size) is introduced to the membranous portion of the urethra. To this instrument a tube passing from the faucet of the bottle is attached, and the water is allowed to run *ad libitum*. I think that the longer this is kept up and the oftener it is performed, the more sure and speedy will be the cure. Chancroids are, as of yore, cauterized and dressed with iodoform. The chancre of syphilis is simply kept clean and dusted with calomel, and if the sore heals kindly no internal remedies, save such as might be indicated to put the patient's system in good condition to resist the disease, are used until other symptoms present themselves, and then the favorite remedy is the famous *pil. duo*," which consists of one gr. of sulphate of iron and two of blue mass, given three times a day. When, again, these symptoms have subsided the medicine is dropped. To make a long story short, instead of two years of mercury the symptoms alone are treated. There is much logic in this plan of dealing with syphilis, but all will admit that it is easier to carry it out in the hospital than in private practice, especially when it is known that the much-dreaded rash may be prevented or masked by continuous treatment from the date of the initial lesion.

**MEDICAL AID TO WOMEN IN INDIA.**—According to the London *Times*, India is indebted to Lady Dufferin for starting a movement which will not only supply a great want, but which also promises

to have a powerful effect in paving the way for the most urgent of all Indian reforms, the amelioration of the position of women. There has just been established under her auspices as lady president, a national association for supplying female medical aid to women in India. The Viceroy is patron, the Governors and Lieut.-Governors are vice-patrons, and their wives vice-patronesses. The object is to supply in hospital wards and within private houses that medical care and advice which respectable native women will only accept from their own sex. It has been decided to make a sustained effort of an unsectarian and national character to organize and stimulate female medical education and facilitate the treatment of native females by women, and to supply trained nurses and midwives for hospitals and private houses. The association will provide scholarships for women under tuition, and will procure from Europe and America a sufficient number of skilled female medical teachers. Here is an opportunity for the female graduates of our Canadian colleges.

**CHLOROFORM FOR TAPE-WORM.**—Dr. Alfred W. Perry, of San Francisco, reports in the *Medical Record* an obstinate case of tænia lata, successfully treated by the exhibition of chloroform. The patient, a stout man, aged forty, had had tape-worm for eight years, on which he had tried all the hitherto known remedies. He always vomited the remedy used within half an hour, retaining longest the French capsules of male fern extract. Dr. Perry had made two attempts to dislodge the worm, without success, when he saw the chloroform treatment noticed in the *Medical Record*. He used it in the following manner, with entire success: The patient was made to fast from 12 m. of the previous day, and only allowed to drink lemonade. At 7 a.m. he took one drachm of chloroform in one ounce of mucilage; at 8 a.m. one ounce of ol. ricini. The entire worm passed about 10:30 a.m. The patient was in considerable stupor shortly after taking the chloroform, which stupor lasted three or four hours. He was a large man, weighing 180 pounds. Dr. Perry thinks that one drachm of chloroform should not be exceeded as a dose.

**SÉE ON THE TREATMENT OF ASTHMA BY PYRIDINE.**—This colorless and strongly-scented fluid is obtained from many organic substances by dry distillation. It has been detected in nicotine and other alkaloids and in the fumes of tobacco. It is probably the active principle of the various cigarettes and papers which have been recommended against asthma. Recent experiments by MM. Sée and Bochetontaine have shown (*Bull. Génér. de Thérap.*) that it produces in frogs and

ginea-pigs a diminution of the irritability of the respiratory centre. Pyridine has been tried in asthma with marked success; 4 or 5 grammes of this fluid are poured on a plate and placed in a small room in which the patient remains for from 20 to 30 minutes, three times a day. The respiration becomes easy, and after a few sittings the disease disappears more or less completely. The inhalations have no bad effects on the heart or general health. In spite of these good results, M. Sée still considers iodine the best curative remedy in asthma; pyridine is chiefly used against the attacks of dyspnea.—*London Med. Record*, Aug.

**BORAX AND NITRATE OF POTASSIUM IN HOARSENESS.**—These two salts have been employed with advantage in cases of hoarseness and aphonia occurring suddenly from the action of cold. The remedy is recommended to singers and orators whose voice suddenly becomes lost, but which by these means can be recovered almost instantly. A piece of borax the size of a pea is to be dissolved in the mouth about ten minutes before singing or speaking. The remedy provokes an abundant secretion of saliva, which moistens the mouth and throat. This local action of the borax should be aided by an equal dose of nitrate of potassium, taken in warm solution before going to bed.

**CORROSIVE SUBLIMATE IN VENEREAL WARTS.**—A correspondent writes us that, having been advised to apply a solution of one grain to the ounce of corrosive sublimate, to a case of venereal warts which came under his care, he found after the application through a mistake a solution of ten grains to the ounce was applied. The result was so satisfactory that he determined to still further increase the strength, and on his next case he made the solution of twenty grains to the ounce with excellent results. He now also applies this solution to chancres and chancroids, and also to indolent ulcers of the uterus, and is highly satisfied with the results. He has never witnessed the slightest symptoms of mercurial poisoning from this treatment, and does not believe that the application of corrosive sublimate in this strength is liable to be followed by absorption.—*Med. Age*.

**USEFUL AGENTS IN THE TREATMENT OF SCARLET FEVER.**—When lecturing upon scarlet fever Prof. Da Costa mentioned the following agents as being of use: 1. Carbolic acid, grt.  $\frac{1}{2}$ , a dose for child two years of age; give in mint water. 2. Ammonium carbonate, gr. ij., every two hours, to child ten years of age. 3. Potassium chlorate,  $\bar{5}$ j., in water, Oj.; patient to drink this in twenty-four hours. 4. Salicylic acid when high temperature is present. 5. Small doses of chloral. Always keep skin active, and if heart be weak, give digitalis—if arterial tension be high, give aconite. When

much exudation has occurred, he prescribed, for its solvent action: R. Ammonii carb., gr. x.; Liq. quor. ammon. acetat., f  $\bar{5}$  ss. M. Sig. Every four hours. If there is much depression, prescribe also quinia and digitalis in combination.—*Col. and Clin. Record*.

**COCAINE IN LITHOLAPAXY.**—Prof. Bruns, of Tübingen, reports a case in which he obtained local anaesthesia of the bladder and urethra by injecting a cocaine solution, with most gratifying results. The patient, a young man, had suffered for four years from stone in the bladder. Chronic cystitis was present, and evening feverishness. The injection of one gramme (mostly into the bladder itself, of a two-per-cent solution, but also a little into the urethra) produced complete local anaesthesia for half an hour, during which time a very hard oxalate of lime calculus was thoroughly crushed and removed without pain. After the injection the patient assumed a different position, to bring the fluid into contact with the whole inside of the bladder; and after the operation a little of a ten-per-cent of iodoform-glycerine emulsion was injected. The recovery was uninterrupted.

**A NEW CURE FOR INDIGESTION.**—Under this heading the *Boston Medical and Surgical Journal* states that a "gentleman of sedentary life, who has long been indisposed with indigestion and the hypochondriac passion, tried riding and several other sorts of exercises but with little effect, was at last prevailed upon, by the advice of an eminent physician, to try being tossed in a blanket. This was accordingly performed every other morning for a fortnight, and has been attended with the greatest success, the gentleman being now much better than he has been for two years past." It used to be reported, in our youthful days, that old John Jacob Astor, when too feeble to stir around, was regularly subjected to this treatment.

**TREATMENT OF CATARRH.**—Dr. Henning says: I have treated hundreds of cases of nasal catarrh in all its various forms and stages, and have tried all kinds of remedies and instruments, and after close observation, have settled upon the following course of treatment:

R Arsenici iodidi..... gr. viij  
Aque dest..... Oj

M.—Sig. Take a teaspoonful three times a day. Continue the remedy for months, in either the acute or chronic form.

Also—

R Potass. permanganas..... gr. iv  
Aque dest.....  $\bar{5}$  iv.

M.—Sig. Pour a small quantity in the palm of the hand and snuff up each nostril sufficiently hard so that the solution will run through the nostrils

and reach the pharynx. Repeat night and morning. This treatment cures a large majority of cases speedily and permanently. I have abandoned all forms of instrument treatments and all but the above, and can heartily recommend it to the profession.—*Med. World.*

**LACTIC ACID IN LARYNGEAL TUBERCULOSIS.**—Dr. H. Krause, in following up the experimental application of lactic acid as pointed out by Mose-tig-Moorhof, who has found it valuable in the local treatment of fungous caries, lupus vulgaris, superficial epithelioma, and papilloma, has made use of the remedy in the local treatment of laryngeal tuberculosis. The cases which he records had previously been under treatment, and a great variety of agents was used without beneficial result. Among the remedies used were iodoformized glycerine, boric acid, carbolic acid, and creasote either with morphia or cocaine.

The cases in which the pathological condition was treated are fourteen in number, and microscopic examination showed the presence of the bacillus tuberculosis in every instance. The results of the local application of the lactic acid were as follows: Hand-in-hand with the decrease of the infiltration and the scar of the ulcer a diminution of pain was noticed, and at the same time diminution of the secretion. The subjective result so far as the larynx is concerned is, that in all the patients, without exception, the condition was markedly improved.

Concerning the return and persistence of the cure after cessation of treatment nothing can be reported, on account of the limited time covered by the observations. Dr. Krause considers, however, that the use of the acid is of certain efficacy in the treatment of this form of tuberculosis, and especially worthy of trial in the light of the failure hitherto experienced in the treatment of this affection of the larynx.

Even in cases in which, owing to far advanced pulmonary tuberculosis, and the general effects of the disease, only a most unfavorable prognosis could be given, the dysphagia accompanying the disease was much diminished by lessening perichondrial oedematous infiltration. The writer further does not hesitate to express a hope that in the least unfavorable cases in which laryngeal tuberculosis has not advanced too far, and the general constitution is well conserved, the use of lactic acid will render it possible to destroy the infiltrated tissue and effect the concurrent cure of the local process. The writer, in conclusion, also suggests the application of lactic acid in other diseases of the mucous membrane of the upper air-passages, among which may be mentioned the diffused swelling and circumscribed thickening accompanying chronic nasal pharyngeal and laryngeal catarrh.—*Berliner klin. Wochenschr.*, July 21, 1885.—*Medical News*, Aug. 22, 1885.

**THE TREATMENT OF DIARRHŒA.**—Dr. John Kent Spender tells us in the *Brit. Med. Journal*, Aug. 8, that more than thirty years ago a combination of laudanum and castor oil was much prescribed for "dysenteric diarrhœa," and he says that he has found the following formula extremely valuable for nearly all forms of sudden and acute diarrhœa, such as we often see in August and September. He combines about two minims of castor oil with three or four minims of solution of hydrochlorate of morphia (*Brit. Pharm.*), and rubs them into an emulsion with gum acacia. To this he adds spirits of chloroform and a little syrup. This is the quantity for a single dose, which may be repeated every hour or two, according to the urgency of the case. If the diarrhœa is chronic, the quantity of the oil is increased, and if there is much pain, more morphia is prescribed. But when this mixture fails or does little good after four or five doses, it may even aggravate the malady to continue it. Warm milk and lime-water is the best food; a mustard poultice may be put on over the stomach, and there should be absolute rest in bed.—*Med. and Surg. Reporter.*

**SULPHATE OF IRON IN THE GASTRIC CATARRH OF INFANTS.**—When absorbents and tonics fail to correct the acidity, Roth ("Pest. med.-chir. Presse"; "Conseiller méd."; "Rev. des mal. de l'enfance") resorts to sulphate of iron, which acts favorably in a variety of ways. In the first place, it is a disinfectant; under its use, the evacuations are changed in color and lose their offensive odor. Being an astringent, it contracts the turgid mucous membrane and coagulates albuminous matters. In order that these effects may be decided, its use should be continued for several days. The author employs the following formula:

R.—Sulphate of iron,	grs. 1½
Mucilage of acacia,	) each 5 5
Syrup.	

A teaspoonful to be given every two hours.—*N. Y. Med. Journal.*

**THE COLD DOUCHE IN INSOMNIA.**—The following is recommended as a very efficacious means of producing sleep in insomnia associated with eruptive or continued fevers: The patient's shoulders are covered with a cloth and the ears plugged with cotton. Then the head being held face down over the edge of the bed, a fine stream of cold water is dropped upon the neck and occiput. The water should fall from a height of eighteen inches during a period of three or four minutes. The head is then dried, and the patient made comfortable in bed. As a general rule, sleep follows in a very short time.—*Concours Médical.*

**UTERINE FIBROIDS IN THE NEGRESS.**—Negro women are almost as exempt from ovarian tumors,

and especially from ovarian cysts, as the Jews are from cancer. When a colored woman consults you for an abdominal or pelvic tumor, the chances are a hundred to one that it is a uterine fibroid. If she gives a history of the slow growth of the tumor and of menorrhagia, and especially if with these symptoms there is an absence of ascites, and the tumor is round, firm, and mobile, you can scarcely be mistaken.—*The Clinique*, May.

**TREATMENT OF LEUCORRHOEA.**—A common source of leucorrhœa is a weeping of the glands about the mouth of the uterus; and this condition we have found specially amenable to treatment by the use of Anderson's vaginal capsules, carrying absorbent cotton soaked in the following solution:

R.—Sodæ bicarb., 5 j.  
Tinct. belladonnæ, 5 ij.  
Aq. calcis, O j.

These capsules are composed of gelatine, and after this has dissolved, the impregnated cotton is left in contact with the os, and certainly has acted with perfect success in our hands, under otherwise adverse circumstances, the discharge having been old and persistent, resisting other methods of treatment.—*Med. World*.

**GASTRO-INTESTINAL INDIGESTION.**—Keating recommends the following treatment of acute gastro-intestinal indigestion in teething children:

R.—Hydrarg. chlor. mit., gr. i.  
Pulv. ipecac., grs. ss.  
Soda bicarb., grs. viij.  
Sacch. lact., grs. x.

M. ft. chart. iv.

This is to be followed by a dose of castor oil, and then the child should be placed on a careful diet for a day or two, and given the wine of pepsin in half teaspoonful doses, or the elix. cinchona co.—*Archives of Pediatrics*.

**TONIC FOR CHILDREN.**—The following is an excellent general tonic mixture for children:

R Potass. bromidi . . . . . gr. 1  
Acid. phosph. dil. . . . .  
Tr. ferri chloridi . . . . . aa 3 ij.  
Syr. limonis, . . . . .  
Aque dest. . . . . aa 3 jss.

M. Sig.—A teaspoonful every four hours, for a child from three to five years old.

**TANNIC ACID FOR NASAL POLYPI.**—Nasal polyp, it is said, can be readily cured by the injection of a solution of a scruple of tannic acid in a fluid drachm of water. Ten to twenty minims of the solution are to be injected into the polypus. The polypus shrivels, dries up, and comes away without pain or trouble.

**EPISTAXIS.**—Prof. Bartholow, for a case of frequent epistaxis, occurring in a young man of twenty-five years of age, recommended the following prescription, to maintain the tonic of the blood—

R Ergotæ (aq. ext.) gr. ij  
Ferri sulphat. gr. j  
Extract. nucis vomicæ gr. ¼ M.

Sig.—In pill, ter die.

*Coll. and Clin. Record*, May,

**FOR ASTHMATIC PAROXYSMS.**—

R Tinct. lobeliæ . . . . . 3 j  
Ammon. iodidi . . . . . 3 ij  
Ammon. bromidi . . . . . 3 ij  
Syr. toltan . . . . . 3 ij

M. Sig. A teaspoonful every one, two, three or four hours.

Dr. Bartholow says that the above "gives relief in a few minutes, and sometimes the relief is permanent."

For cholera infantum Dr. J. Lewis Smith recommends:

R.—Tinct. opii, gtt. xvj.  
Spt. ammon. aronat., 5 ss. to j.  
Bismuth subnitrat., 5 ij.  
Syr. simplicis, 3 ss.  
Mistur. cretæ, 5 jss.—M.

Sig.—One teaspoonful every two or three hours to a child of eight to twelve months, until vomiting and diarrhœa are controlled.

**ANTI-HEMORRHAGIC.**—Five minims each of spirits of turpentine and tincture of hamamelis in an ounce of mist. amygdalæ may be given three times a day, with marked benefit in hæmatemesis, hæmoptysis, and menorrhagia.—*Texas Cour.-Rec. Med.*

**BISMARCK AND HIS PHYSICIAN.**—It is certain that Bismarck's physician, though a charlatan, is no fool. It is related that when first presented the Prince was sick, and peevishly declined to answer questions. "As you like," said the doctor, "then send for a veterinary surgeon, as such practitioners treat their patients without asking them any questions." The Chancellor was captured.

**DR. J. T. EMER**, of South Waterboro, Me., says: I have tested PAFINE thoroughly and I will say I am well pleased with it, as it is superior to Opium in all respects, or anything of the kind, as it does not constipate or cause nausea as does Opium and its other preparations, I shall continue to use it.

**TO DISGUISE THE TASTE AND SMELL OF TURPENTINE.**—The taste and smell of turpentine are best masked by sulphuric ether. A mixture of turpentine, 3ij; ether, 3j; syrup of orange, 3j; and water, 3iv; can be taken in teaspoonful doses quite readily.



# THE CANADA LANCET.

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Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

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## MEDICAL ACT VS. QUACKERY.

From the tone of the correspondence in our last number, we infer that considerable doubt exists in the minds of certain members of the profession regarding the utility of medical legislation, especially in the suppression of quackery. The younger men in the profession are especially prone to say that it is useless. They have paid certain fees, and have been obliged to take a long and expensive course of preparation. After beginning their professional career they meet with many unexpected obstacles and difficulties, but most of all the irrepressible quack. He does not "hang out his shingle," nor as a rule flaunt himself before the public as formerly; but he is there all the same, and hence the young practitioner, who knows nothing of by-gone times, fancies that he spent his money and time for nought. But let us for a moment contrast the past with the present. Formerly, a considerable number of those practising, either had no previous training, or had taken but a partial course. Anyone was at liberty to attach M.D. to his name and announce himself qualified to practise medicine. About the only barrier was inability to collect fees by process of law. There were three systems or schools authorized by law, each holding corporate rights. Two of them had no schools or colleges, yet they were able to graduate doctors with amazing facility. The third had several faculties, but owing to rivalry their standard was somewhat low and behind the require-

ments of the times. Each year doctors were turned out in great numbers, and altogether beyond the requirements of the country. Professional dignity and standing were at a low ebb. An M.D. was thought no more of than a K.C.B. is now, and cultured medical men thought themselves degraded by the company they were compelled to keep. In short, pathies were multiplying, quackery was rampant and audacious, and but a brief space longer and the country would have been captured by the charlatans.

Such is a brief representation of the unhappy condition of things, when some of the more thoughtful of the profession began an agitation for reform. These men asked the legislature for fresh legislation, and after encountering many defeats and disappointments, they were at length successful.

Instead of three separate systems or schools recognized by law, the law now knows no particular system or doctrine, and instead, demands a thorough preliminary and professional education, without regard to dogmatic opinions,—thus uniting and exalting the whole into one strong and dignified body. Every candidate seeking admission into this body must pass through a long course of arduous labor, and before admission, prove himself well skilled in all that pertains to the practice of medicine. Graduates are no longer turned out in hundreds, and none but competent persons find their way into the profession. To be sure, we still have the quack with us, but "he is not numerous." Pressed as he now is, and will be, according to natural law, a few years more and he will all but have disappeared. A "look at this picture, and then at that," is surely enough to convince any reasonable mind that the Medical Act has most fully met the ends for which it was created. All who remember the utter chaos, under the old order, cannot but wonder how successful the law has been and how much good has been accomplished, both in the interest of the profession and the public at large.

The Medical Act does suppress quackery, and besides, does many other good things, of which we should feel proud. It has brought order out of chaos, harmonized discordant elements, advanced education, and given a standing and dignity to the profession not enjoyed in any other country.

But after all, the medical profession are but co-partners under the law. This is an element in

the question too generally left out of consideration. The people have a voice in this matter. No legislature could have been prevailed upon to pass a law creating a medical monopoly irrespective of private rights. The privileges and immunities granted are assumed to be reciprocal between the profession and the people. We are indebted to the people for the encouragement and protection we receive from the law, and the people are indebted to us for the higher skill and the better protection to health and life we are able to give in return. Let no one think the law was framed solely in the interests of the profession. The public interest is paramount, and can never be lawfully subordinated to individual or corporate rights. Some members of the profession would do well to consider these things, and ask themselves the question: Have we been expecting too much, and more than any law could confer? There is a law against theft and murder, but that does not absolutely prevent these crimes, and no one would argue that the law should therefore be abolished. As no law can ever change the propensity to do evil, so no legislative enactment can absolutely prevent the perpetration of crime. Quackery is an offence most difficult, if not impossible to suppress. In spite of all laws, we shall always have with us the quack, as well as his willing dupes. We must rest satisfied with making him an outlaw, and causing him to move darkly and operate within narrow limits, just like the thief or highwayman. That the law does suppress quackery is certain, but whether we have reached the highest point in that behalf is another matter. The question has been a difficult one to deal with from the start. In the passing of the law the legislature tempered it with mercy for the quack, by providing for the registration of all persons in practice for two years and over, irrespective of any other qualification. This left out in the shade a good many better qualified than some who were permitted to register. Then there was the question of public sentiment. The people were not always able to see why all the pretenders should be exterminated. A policy of tolerance was also stoutly maintained by influential organs of public opinion. Under such circumstances a relentless prosecution of the quacks might have resulted in tumbling the whole fabric over our heads. Successive Councils recognized these facts, and foreseeing the danger,

wisely resolved to make haste slowly. The results are a sufficient justification of the wisdom of that policy. With the lapse of time, however, all these considerations have been losing in force. Nearly all the old quacks and irregulars have passed off the scene, and those now found contravening the law are mostly persons who entered upon their course fully cognizant of the criminality of their acts. Such persons can lay no claims to mercy, and ought to be dealt with to the full measure of the law. No doubt public opinion has also undergone a change, and would now not only tolerate, but look with favor on the punishment of all quacks.

The Medical Council at its last meeting authorized each territorial representative to appoint one prosecutor. That was tried before and found inadequate. There should be one at every important centre of population. One detective for a whole district is almost useless. Of course, prosecutions must always be more or less under the direction of members of the Council. This is necessary to the exercise of judgment and discrimination, and to prevent harsh and uncalled-for prosecutions, as, for example, in the case of foreigners called to see special cases, or acting in emergencies.

#### LOCAL HEALTH OFFICERS.

The organization throughout the Province of Ontario of local boards of health opens up a new field in medicine. Already there are between two and three hundred boards organized. A large proportion of these, indeed nearly all of them we believe, have each a medical health officer associated with the board. There are over six hundred municipalities in the Province, and in accordance with an Act passed by the Legislature last year, each one is required to organize a local board of health, or, failing to do so, the Government may appoint the board. In a short time, therefore, there will necessarily be a board in every municipality. It is altogether probable that nearly every board will appoint a medical practitioner, who will be the chief officer, and nearly one-third of the medical practitioners in the Province will therefore be directly associated with the local boards of health, engaged in the prevention of disease.

There are two points of special interest in connection with this subject which we desire to refer to. The first relates to the duties of the medical

health officer; the second to the remuneration for his services. With regard to the duties of the medical health officer, many people appear to think that they consist in great measure in prying about into back lanes, alleys and back yards, seeking for manifest and manifold causes of disease. We need hardly say, such forms no part of the duties of the medical officer, but of those of an inspector, which every board of health should employ. The medical officer's duties are largely of an advisory nature. He is to decide as to what is or is not injurious to the public health. He must be familiar with the Public Health Act, and he should advise and urge the board to adopt all reasonable practical measures for preventing the development and spread of disease. On the outbreak of any epidemic disease his advice is particularly desirable, as relates to isolation, the providing of proper hospital accommodation, disinfection, and to the time when danger from the infection shall be over. His advice should be sought in reference to the water supply, whether of wells or other sources, and to the milk supply, while he should see that inspection of the latter is properly carried out. He may urge the necessity for draining certain localities. In short, he should endeavor to have a good sanitary system adopted by the board for the municipality, and to see that it is properly carried out in all its various parts. The position of a medical health officer who takes a deep interest in preventive medicine is no sinecure.

With reference to the question of remuneration, we would recommend medical practitioners not to demand high fees or salaries when requested to accept the position of medical health officer. To do so would be against the best interest of the public health. At this early period in the development of preventive medicine, it would deter many municipal authorities from engaging the services of a medical man. While this would of course be a much greater disadvantage to the public than to the profession, it is the duty of the physician to consider first the interests of the public or of the community in which he lives. Hence it would be well for him to demand only what that community are willing, rather than what they may be able, to pay. In this way the physician will help to develop a most desirable system, in which the profession will become very generally employed in that branch of medicine which is the most elevating

and important of all—that of directly promoting the public health by the exercise of their skill in preventing disease. Notwithstanding the desirability of medical practitioners being very reasonable at first in their demands for such services, we trust that they will at the same time let municipal authorities understand that their services in their behalf are most valuable to the community, when thus associated with boards of health in efforts to prevent sickness, and therefore the municipality must fairly remunerate them for such services. Moreover, to accept a position of the kind at a merely nominal salary, or per diem fee, or honorarium, would be an injustice to other practitioners, which should not be overlooked. The wisest course, then, would seem to be for physicians to demand a moderately reasonable consideration for the commencement, with the view of an increase in the future.

#### CANADA MEDICAL ASSOCIATION.

The eighteenth annual meeting of the Canada Medical Association was held in Chatham, Ont., on the 2nd and 3rd ult., the President, Dr. Osler, in the chair. There was a large attendance of members present. A number of American physicians were also present, and most heartily welcomed to all the privileges of the meeting. Hon. Dr. Sullivan, the retiring President, opened the proceedings by a short speech, in which he congratulated the Association on the excellent arrangements made for the meeting, and the programme which had been provided. He alluded to the very creditable part taken by the members of the medical profession in the North-West Rebellion, and the satisfactory manner in which the sick and wounded were cared for. He also referred in a complimentary way to the President elect, Dr. Osler, of Philadelphia, whom he installed in the chair.

In the afternoon the President delivered the annual address which was listened to with marked attention. The subject was the history and progress of medical education in Canada. On motion of Dr. Grant, of Ottawa, a vote of thanks was tendered to the President for his able and interesting address. The Association then divided into sections, Dr. Harrison, of Selkirk, being elected chairman of the medical section, and Dr. Edwards, of London, chairman of the surgical section. The

papers in each section were interesting and instructive, and were very fully discussed. Several of these papers will appear in future issues of the LANCET. The dinner which was given by the brethren in Chatham on the evening of the first day was a most magnificent spread, and the proceedings were thoroughly enjoyed. The speeches were excellent after-dinner efforts, and the night was far spent before the entertainment came to a close.

The first order of business on Thursday morning was the election of officers. Dr. Holmes, of Chatham, was elected President, and Quebec chosen as the next place of meeting. The election of Dr. Holmes as President for next year meets with the greatest favor. He and the other physicians of Chatham were most indefatigable, and made the meeting there most pleasant. The General Secretary, Dr. Stewart, of Montreal, is the right man in the right place, and has already shown his ability for the office to which he has been re-elected.

#### PERSONAL EXPERIENCE OF A PHYSICIAN IN THE USE OF BEEF PEPTONIDS.

Clinical evidence as to the value of Messrs. Reed & Carnrick's new preparation is being freely tendered, while chemists of the highest eminence pronounce it the most perfectly concentrated nitrogenous food yet offered for examination. Personal experience of its use is, naturally, of more rare occurrence, and we consider the testimony of Dr. Bell of so much interest to the profession as to call for its wide publication. We subjoin Dr. Bell's letter, and fully endorse his estimate of the recuperative properties of this admirable preparation :

YARMOUTH, Nova Scotia, Sept. 3, '85.

For the first three months of current year I was prostrated with gastric trouble, and for seven days, during latter part of third month, found it impossible to retain food upon the stomach. In this exigency Pepsin of various leading brands, as also bismuth (in powder and solution), oxalate of cerium, and ingluvin, were successively tried with no beneficial result. So obstinate and pertinacious indeed was the attack of emesis that indications pointed strongly to fatal results through inanition. At this juncture "Beef Peptonoids" was suggested by Mr. O. C. Richards, a local druggist, as worthy

of trial, and was taken up as a *dernier ressort*. Notwithstanding the fact that this preparation is continuously advertised in the medical journals, I had never tested it in my practice, and was hopeless of profit from its use after having failed with all the generally accepted remedies. The result, however, was so markedly beneficial, and the preparation so quick in action, that I consider it my duty to the profession to place my personal experience on record.

The first day's use of the Beef Peptonoids gave notable relief and accession of strength; on the second day the vomiting was materially reduced with steady improvement until the fifth day, when this distressing feature was entirely eliminated from my case. Convalescence was rapid under continuance of this treatment.

I need hardly add that the preparation holds high place in my esteem. I have prescribed it in many critical cases, and have no hesitation in testifying to its extraordinary recuperative properties. In dyspepsia I have found it a most valuable agent as a nutrient after childbirth it has done excellent work in my practice—materially increasing the quality and flow of milk,—and indeed, in all asthenic conditions I have proved it to be a constructive of rare merit.

GEORGE BELL, M.D.

#### JOHN MACKIESON, M.D.

We regret to announce the death of Dr. Mackieson, of Charlottetown, P. E. I. He was the oldest practitioner in Canada, having been in practice for nearly three-quarters of a century. He was a native of Stirlingshire, Scotland, was born in 1795 and was consequently in his ninety-fourth year at the time of his death. He graduated in Glasgow University in 1815, and emigrated to Charlottetown in 1821. For fifty-five years he was an elder in St. James' Presbyterian church in his adopted city. At one time he was Superintendent of the Hospital for the Insane. His library contains some very rare and ancient books, and he has left the manuscript of a work on "Prescriptions and Prescribing," which we trust the administrators will hand over to some publisher.

THE RADICAL CURE OF HERNIA.—The operation for radical cure of hernia is not performed in this country nearly as often as is demanded. We can see no reason why a simple, reducible hernia should not be operated upon for radical cure in all cases, and more especially in children and persons under

middle age. It is eminently more rational to perform the operation with a slight risk than to have our patients pass through life constantly wearing a cumbersome truss, or with the troublesome annoyance of a scrotal hernia, which is almost certain to increase in size gradually.

The English surgeons, of late years, are performing the operation for radical cure with impunity; we are doing it, as a rule, only when the operation is forced upon us as the only relief for strangulated, irreducible hernia. Under these conditions the operation is demanded, but in many cases is postponed until inflammation has supervened, either through rough manipulation, or severe strangulation long continued. We will venture the assertion that more deaths have been caused by strangulated hernia than would have occurred from the operation for the radical cure. Those who have hernia are never free from danger of strangulation, and hence their lives are constantly in jeopardy from this cause.

The number of trusses sold is indicative of the number of persons suffering from hernia, and the same is also indicative of the number adjusted by physicians, very few of whom, if any, advise operation or warn the patients of the danger they are subjected to. There are many different modes of operating, but we will not refer to them. In all the operations there is but one incidental danger of any magnitude—peritonitis—all other dangers being merely accidental. The bowel may be accidentally punctured by deep sutures, the cord or vessels may be injured or tied in the operation, or the vessels may be punctured. These possible dangers are trivial, however, and need scarcely be mentioned. We admit there is some little danger accompanying the operation; still we hold that in proper cases the dangers are not in proportion to the relief and advantages.

The time is in the near future when this operation will be the rule in properly selected cases. There have been, and probably always will be, some failures, and a few deaths, but such, as shown by statistics in England, are extremely few, and can offer no comparison to the relief afforded.

**THE INTERNATIONAL MEDICAL CONGRESS.**—The committee appointed at the meeting of the American Medical Association in New Orleans, met in New York on the 3rd ult., to fill the vacancies

caused by the resignation of previously appointed officers of the Congress, and adopt rules for the government of the Congress. One of the first acts of the committee was to rescind the rule which closed the doors of the Congress against all who were not members of the association or of societies in affiliation with it. Any member of the regular profession may become a member of the Congress. The fee for membership is ten dollars, but no dues shall be exacted from foreigners. Dr. Flint, Sr., is to be President and N. S. Davis General Secretary. These gentlemen are well known both at home and abroad, but many of the Presidents of Sections are scarcely known to the profession of their own country. It seems a pity that the committee had not gone a little further and removed all impediments to a complete success of the coming Congress.

**HOSPITAL FOR WOMEN.**—We are pleased to announce that a hospital for women has been opened in this city, in connection with the sisterhood of St. John the Divine, of the Church of England. In noticing the leading features connected with this hospital, we desire to congratulate the Mother Superior, who mainly by her own efforts has been instrumental in completing this work, upon the large measure of success which she has achieved. So far as the profession is concerned, the chief advantage in having this hospital in our midst, is, that within its walls any regular practitioner will be permitted to introduce patients and have their treatment in his own hands, subject only to the rules governing the institution, which are such as may be cheerfully complied with. The hospital will at present accommodate between ten and twelve patients, in pleasant, well-ventilated and convenient rooms. Three beds are set apart for poor women who are unable to pay anything towards their maintenance and treatment, whilst the remainder of the hospital is for patients who are able to pay according to their means. The sisters will act as nurses, and from their careful training and lives devoted to a holy calling, it is reasonable to expect that nothing will be wanting in this respect. The building was formally opened and dedicated by the Bishop of Toronto a few weeks ago. It is situated on the corner of Lunley and Robinson streets. For the guidance of practitioners in the country, who may wish to send

patients for treatment, information will be gladly furnished by communicating with the Mother Superior. We confidently predict for the hospital a grand and useful future.

**EXTRA-UTERINE FETATION.**—The successful treatment of a case of extra-uterine foetation by means of electricity, is reported by Dr. Gardner (*Can. Med. and Surg. Journal*, Aug.). A strong Faradic current was applied. One electrode—an olive-shaped insulated metallic bulb, covered with chamois leather—was introduced into the rectum. The other—an ordinary sponge electrode—was applied over the tumor in the hypogastrium. The applications were of seven minutes duration, and repeated for some time daily. On the second day exfoliation of the decidual membrane of the uterus took place, accompanied with a bloody discharge. The tumor presented symptoms of inflammation, and suppuration was at one time anticipated, but did not take place. The patient made an excellent recovery.

**REMOVAL OF PLASTER BANDAGE.**—Dr. Krosz (*Deut. Med. Zeitung*), says that the removal of a plaster-of-Paris dressing is greatly facilitated by first scraping a groove with a knife and then dropping along it a solution of caustic soda. In a few moments the plaster becomes pulpy along this line, and the bandage can then easily be cut through. If two lateral grooves be made, instead of one, a lid can be cut out of the bandage, the leg can be lifted up for the necessary inspection and returned, the lid being reapplied and retained with a roller bandage. In this way the plaster dressing is not cracked and the limb is not jolted in the efforts to remove the bandage. By this method, also, it is a very easy matter to cut any fenestra that may be needed.

**IPECACUANHA IN HEMOPTYSIS.**—According to Dr. Bartholow ipecacuanha is a "remarkable physiological remedy" for hemoptysis. He combines it with ergot in equal quantities, using five minims of the fluid extract of each drug for a dose. This is repeated as frequently as the urgency of the case may seem to require.

**ERGOT IN NIGHT-SWEATS.**—Prof. DaCosta (*Col. & Clin. Record*) says that in the treatment of the night-sweats of phthisis ergot is preferable to

atropine, being more permanent in its effects, and does not produce the dryness of the throat which so frequently follows the administration of atropine. He recommends two grains of ergotin thrice daily, the last dose to be given at bed time.

**THE PANAMA CANAL.**—Dr. W. Nelson, late of Panama, read a paper before the Natural History Society of Santa Barbara, Cal., in which he stated his belief that the canal was a commercial impossibility. It will cost \$400,000,000 to complete it and no existing tonnage would pay interest on the investment. The death rate among the canal men has been appalling owing to intense malarial poisoning and yellow fever. Owing to the large amount of sickness, a vast system of hospitals has been erected at Panama, costing upwards of two and a quarter million dollars.

**SUCCESSFUL TRANSPLANTATION OF THE RABBIT'S EYE.**—A case of enucleation of the human eye and transplantation of the rabbit's eye is reported by Dr. H. N. Bradford in the *Boston Med. and Surg. Journal*, Sept. 17. The patient was 35 years of age. It is stated that the transplanted globe contained adhesions and circulation was established. Of course there was no vision, but the æsthetic effect was very good, much better than that of an artificial eye.

**REDUCED IRON IN ANÆMIA.**—Dr. Martin of Sheffield, Eng., has been experimenting with reduced iron in the treatment of anæmia, and thinks that it is one of the most powerful remedies which we possess in restoring the condition of the blood, in all anæmic states. He gives the ferri redactum in the form of pill combined with extract of nux vomica, three grains of the former to  $\frac{1}{8}$  grain of the latter. The results have been very satisfactory.

**FAREWELL PRESENTATION.**—The officers and attendants of the Asylum for Insane, London, presented Dr. Millman with an address, accompanied with a valuable gold watch, on the eve of his departure for Kingston, to assume the duties of Asst. Supt. in the Rockwood Asylum, to which he has been recently appointed. The Dr. carries with him the best wishes of a large circle of friends and acquaintances in London and elsewhere.

**ODORLESS IODOFORM.**—The complete deodoriza-

tion of iodoform has been the subject of an extensive series of experiments by Dr. Oppler, of Strasbourg. He recommends finely-powdered roasted coffee as the most suitable substance. The formula which he gives for the ointment is as follows :

R.—Iodoform, 1 part.  
Paraffine ointment, 10 parts.  
Roasted coffee, finely-powdered,  $\frac{3}{10}$  part.

**APPOINTMENTS.**—Dr. J. R. Clarke has been appointed Medical Health officer for Cobourg. Dr. L. Robitaille has been appointed inspector of customs at Quebec. Dr. R. McIntyre, of Hespeler, has been appointed surgeon of the Waterloo Battalion of Infantry, *vice* W. H. Vardon, M.D.; and Dr. J. H. Radford, of Galt, assistant surgeon.

**CORONER.**—Dr. W. Allen, of Janetville, has been appointed coroner for the United Counties of Durham and Northumberland, Ontario.

**REMOVAL OF A CYSTIC KIDNEY.**—Dr. Hingston, of Montreal, recently removed the kidney for cystic disease of that organ. The patient, a young lady, made an excellent recovery. We believe this is the first operation of the kind in Canada, and we are pleased to learn that it has been successful in its results.

We beg leave to express our deepest sympathy for Dr. Covernton of this city, in the recent death of his son, of typhoid fever. This is the second sad bereavement through which the Dr. and his family have been called to pass within the period of three months.

THE death of Dr. Milne Edwards, of Paris, is announced in our exchanges.

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## Books and Pamphlets.

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**ASIATIC CHOLERA**, Edited and prepared by E. C. Wendt, M.D., in association with Drs. John C. Peters, of New York, Ely McClellan, U.S.A., John B. Hamilton, Surgeon General U.S. Marine Hospital Service, and George M. Sternberg, U.S.A.

The above publication is the May volume of "Wood's Library of Standard Medical Authors." If division of labour may be regarded as a reliable guarantee of the completeness of scientific work,

we may reasonably suppose that this book will command the attention of the studious majority of the medical profession; and we must confess that after a very thoughtful perusal of its 400 pages, we are bound to admit that the several writers have ably discharged the duties assumed by them. The general history of Asiatic cholera, which constitutes the first part of the volume, is from the pen of Dr. Peters, who appears to have bestowed ample and close research on this difficult and truly important portion of the work. Dr. Peters has traced the disease from the earliest European record of its prevalence in India, up to the present time, following it through its various wanderings, over almost the entire surface of the globe. He is a strongly pronounced contagionist, and it must be truly very difficult to any logical and unprejudiced reader, to dispute his decision.

The second, third, fourth, fifth, and seventh parts of the work have fallen upon Dr. Wendt, who has given abundant proof of the energy and industry with which he must have devoted himself to his arduous task, which comprised the etiology, the symptomatology, etc., etc., the morbid anatomy and pathological histology, the diagnosis and prognosis, and finally the treatment of cholera.

It might almost go without saying that Dr. Wendt is a firm believer in the comma bacillus of Koch. The mere orthography of his name affords sufficient promise of his fealty to the great German microbist, and assuredly Koch has in Wendt no feeble ally.

The sixth part of the work includes: The destruction of cholera germs, by Dr. Sternberg; the prevention of the spread of cholera, by Dr. Hamilton; and cholera hygiene as applied to military life, by Dr. McClellan. At present, when, if history repeats itself, and assuredly the history of Asiatic cholera has, in the past, been faithful to the legend, we may, before any great lapse of time, have to encounter another visitation of the dire pestilence, the admonitions of the above three largely experienced medical gentlemen must command the deferential consideration of every reflecting reader. They are not mere babbling theorists, impelled to relieve themselves of those gaseous distentions which are the normal overflow of ignorance heated by irrepressible vanity; they know whereof they speak, and they have spoken as the lovers of truth and of humanity never fail to do.



THE POPULAR SCIENCE MONTHLY for September, 1885. New York: D. Appleton & Co. Fifty cents a number, \$5 a year.

Dr. W. T. Barnard has the lead in the September "Popular Science Monthly," and opens an able and elaborate discussion on "The Relations of Railway Managers and Employees." The paper is very interesting. Dr. W. G. Thompson considers "The Present Aspect of Medical Education," and gives much information and many valuable suggestions upon the subject. Dr. Mary Putnam-Jacobi concludes her essay, "An Experiment in Primary Education," in the present number. It is a practice with her own child, and is full of originality. "The Fauna of the Sea-shore," by Moseley; Dr. Brehm's "Siberia and the Exiles"; "How Spelling damages the Mind," by F. A. Fernald, are readable papers; while that by Professor Langley, on "Sunlight and the Earth's Atmosphere," is a brilliant and striking article. Dr. Ray Lankester makes a report on "The Recent Progress in Biology."

HAND-BOOK OF DISEASES OF THE SKIN, by H. Von Ziemssen. Illustrated with 80 wood engravings and color prints. New York: Wm. Wood & Co.

This excellent work has been prepared expressly for presentation to subscribers to Ziemssen's Cyclopædia of Medicine, and the publishers will esteem it a favor if all subscribers will at once send them their present address, also their address at the time they subscribed. The work is not a part of the Cyclopædia proper, and does not conform to that work either in size, shape, type or binding. The publication of a volume of such size and high character for free distribution to many thousand persons is without precedent, and deserving of the heartiest appreciation.

A TEXT-BOOK OF PHYSIOLOGY. By M. Foster, M.A., M.D., F.R.S., Prælector in Physiology, Trinity College, Cambridge. Third American from the Fourth English Edition. With Extensive Notes and Additions by Edward T. Reichert, M.D., Demonstrator of Experimental Physiology in the University of Pennsylvania. With 271 Illustrations. 12mo. Pp. 911. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

This work has been before the profession for several years and is now so well known that a notice is scarcely necessary. Numerous additions have been made to the present edition, which will

largely increase its value and usefulness to the general student. The work is on the whole one which embraces in a special manner, those portions of the science which are essential, such as the blood circulation, digestion, respiration, locomotion, etc. We commend the work to the attention of all students of physiology.

CLINICAL STUDIES ON DISEASES OF THE EYE. By Ferdinand Ritter von Arlt, M.D. Translated by Lyman Ware, M.D. 8vo. Cloth. 325 pages. Philadelphia, P. Blakiston, Son & Co., 1885. Price, \$2.50.

This work of Prof. Arlt's, written on the eve of a long and useful career, extending over almost half a century of ophthalmic practice, merits a cordial reception at the hands of the profession. A work of this kind, as the editor states in his preface, is distinct from an ordinary text book, and is always welcome both to the general practitioner and the specialist.

LECTURES ON THE PRINCIPLES OF SURGERY. By W. H. Van Buren, M.D., L.L.D., late Professor of Principles and Practice of Surgery in Bellevue Hospital Medical College. Edited by Lewis A. Stimson, M.D., Professor of Clinical Surgery, in the University of the City New York. New York: D. Appleton & Co. Toronto: Williamson & Co.

One of the reviewers of this work has said that it should have been styled "The Philosophy of the Science of Surgery" in contradistinction to many others which plainly essay the art alone. This statement is indeed not very wide of the mark, as it is undoubtedly a work of superior merit. It is a systematic exposition of the subject by a master hand, and evidences thorough and careful preparation. The work has been printed from the manuscripts of his lectures on this subject, edited by Dr. Stimson, of the University New York.

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### Births, Marriages and Deaths.

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On the 6th of August, R. S. King, M.D., of Port Robinson, aged 68 years.

On the 16th ult., J. Stuart McCullough, M.D., of Hillsburgh, aged 23 years.

On the 14th ult., H. Skinner, M.D., of Kingston, Ont., aged 49 years.

On the 18th of August, A. E. Fife, M.D., of Brighton, aged 63 years.

# THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

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## Original Communications.

### THE RELATION BETWEEN EPIDEMIC ERYSIPELAS AND PUERPERAL FEVER.

BY J. E. JENNER, M.D., C.M., L.R.C.P. L., PICTON, ONT.

About the middle of the last century an epidemic of puerperal fever broke out in Paris, and an eminent French physician writing on the subject, stated that the puerperal fever then prevalent was an erysipelas of the peritoneum. But this view did not attract much attention for about a hundred years, when several English and American writers published, almost simultaneously, accounts of numerous epidemics as well as isolated cases of puerperal fever evidently traceable to erysipelatos inoculation, and now the intimate and reciprocal relationship existing between these two diseases is admitted by all authorities, the poison of either disease being capable under favorable circumstances of producing the other. Thus, puerperal women exposed to the poison of erysipelas are almost certain to contract puerperal fever, and their babes frequently die within a few days of erysipelas neonatorum. On the other hand, wounds dressed by a surgeon in attendance on puerperal fever patients, often take on an erysipelatos nature. Dr. Cox relates, that a physician having bled an erysipelatos patient, soon afterwards used the same lancet to bleed a man injured by a fall and also a woman in labor. The man developed an attack of phlebitis and the woman of puerperal fever.

An instance which occurred in my own experience well illustrates the reciprocal relation between these two diseases. In April, 1884, I was called to see a woman who was "flowing badly." Her husband told me she was in the sixth month of pregnancy and had miscarried the day before. When I saw her she was quite blanched, the bed-

ding was saturated with blood and about a quart of clots were lying on the sheet. She had lost considerable blood the day before and was still flowing pretty freely. Having a fair pulse and not manifesting symptoms of immediate collapse, I determined to remove the placenta at once, which could be felt protruding from the os and partly in the vagina. Being accustomed to taking stimulants freely, I gave her a glass of brandy and water, and inserting my hand into the vagina, detached the adherent portion of placenta by insinuating two fingers between it and the wall of the uterus, first having tried—without success—Credé's method of expression. (The placental attachment was at the "meridian zone."—Barnes). I had no difficulty in removing the placenta and am satisfied it came away entire, and that no portion of the secundines were left behind. The hæmorrhage ceased immediately; I gave her two grains of opium in powder and washed out the uterus with a 2 % solution of carbolic acid, using at least two quarts, the water being as hot as my hand could bear it. There was neither hæmorrhage nor pain after this, save some intermittent after-pains, the result, I presume, of the ergot I had given her immediately upon seeing her. This was in the morning; about 2 o'clock that afternoon she had a marked chill and when I saw her in the evening her temperature was 102.5° F. I again washed out the uterus and left two 10 gr. powders of quinine to be taken during the night. She had no pain whatever. The following morning I found her very restless and anxious about her condition, the features cold, pinched and bloodless, the expression haggard and anxious; temp. 104.5° F., pulse 140, resp. 48. There was profuse sweating, had been a rigor about an hour before, and the extremities were cold. She had all the symptoms of malignant puerperal fever, and died on the fifth day. I was at the same time attending a case of phlegmonous erysipelas some miles away, and although I had taken the precaution to disinfect myself thoroughly and change my clothing, I believe I was the means of carrying the infection to my puerperal patient. She had miscarried on several occasions before. On the evening after her funeral two of her children, a boy æt. 13 years and a girl æt. 6 years, were suddenly attacked with vomiting, sore throat and headache. I saw them on the day following and pronounced them both cases of scarlatina. The next day the

rash covered the body and there was then no doubt as to the nature of the disease. Both patients did well on the simplest treatment, the type being a mild one, they had reached the beginning of the fourth week, desquamation was almost completed and both children had been up some time—though this was contrary to orders—when the little girl manifested symptoms very similar to those which ushered in her recent illness. Her father prescribed some domestic remedies, salts, smartweed tea, etc., but the patient getting no better—but rather worse—he sent for me on the third day. I found the patient excited and tremulous, face flushed and swollen on one side; pulse 160, quick and full; temp. 104.5° F. She had intense headache and delirium at times, a dry, brown, tremulous tongue. Behind each ear was a patch of eczema, which had broken out afresh since desquamation after scarlatina. Her father said “she was subject to sore eyes.” The right ear was swollen to several times its normal size, and large blebs full of sero-purulent fluid were to be seen. The redness and swelling had spread well over the right side of the scalp and face, the right eye being swelled shut. The case was obviously one of cutaneous erysipelas of the head and face, the point of departure being doubtless the eczematous sore behind the ear. The inflammation extended over the head, face and neck, travelling over the entire trunk and down the extremities to the knees and elbows, where it stopped. In its progress over the body and limbs, the redness advanced about two inches each day and did not last longer than forty-eight hours in one place, fading away in about two days. The margin was well marked, raised and irregular. The temperature ranged between 102° F. and 104° F., until the beginning of the fourth week, by the end of which it had subsided entirely, and the skin—after a thorough washing with soap and water—had resumed its natural color and appearance.

I ordered rest in bed in an airy room, shaved the head and put on hot linseed-meal poultices, and painted the face and soft parts with a mixture of collodion and castor oil—equal parts. Prescribed quinine, iron, and chlorate of potash in full doses, digitalis and other diuretics as required, and restricted the diet to fluids, milk eggnog, beef tea, animal broths and some farinaceous food, keeping the bowels relaxed by castor oil, glycer-

rhiza and other mild aperients. The local treatment of the body and extremities, consisted in poultices until the redness disappeared, followed by inunction with Kentish's ointment, repeated each morning for two or three days. There was some albumen in the urine, probably the sequel of the scarlatina she had just recovered from.

On the third day after I was called to see this patient, her brother, who had accompanied her through the attack of scarlatina, also developed erysipelas. In his case the eruption was confined to the mucous membrane of the nares, the bridge of the nose and the soft tissues below the eyes. It was perfectly symmetrical, and both nares were almost occluded for a time. His temperature ran up to 103° F. for a few days, with other constitutional symptoms of a mild type. Free action on the bowels, with quinine, iron, and chlorate of potash, rest in bed, topical application of ol. ricini and collodion, with the usual precautions in the matter of diet, sanitation, etc., constituted the treatment in his case. In a week he was quite well.

REMARKS.—Since the mother's death these two children had slept in her bed with the father. None of the other members of the household had been thus exposed, and there were several small children in the house, among them a babe two months old, belonging to the housekeeper. None of these suffered from either disease. Though the bed-linen and coverlets had been washed and thoroughly cleansed after the mother's death, and the mattresses and pillows aired, I still think that both the scarlatina and erysipelas in these two children may have been due to infection from the puerperal fever poison, by sleeping in the same room and on the same bedding so soon after the mother's death. There were no other cases of erysipelas in the neighborhood, and although scarlatina had appeared in the school, neither myself nor any members of the family had been exposed to the disease. Many authorities believe a close relationship exists between scarlatina and puerperal fever, but whether this relationship be reciprocal or not, is, I think, not yet established.

It is laid down as a rule and taught in the schools, that when a practitioner has been unfortunate enough to get a case of genuine puerperal fever, he should at once give up his midwifery practice for a period of at least three weeks, and

dévôte his attention in the meantime to daily ablutions until he is purified from the contaminating influence which attends him. Now if it be true, as it undoubtedly is, that the contagium of erysipelas is capable of developing in a puerperal woman genuine puerperal fever—and indeed the opinion is prevalent among the French that every case of puerperal fever is an erysipelatous inflammation of the peritoneum—it follows that during epidemics of erysipelas the practice of midwifery must be relegated entirely to inexperienced women—technically called midwives. There is no doubt that the doctor assumes some risk in attending the lying-in chamber while being daily exposed to the virus of erysipelas; still I believe it is quite possible for the accoucheur to so thoroughly disinfect himself, as to guard effectually against the danger of communicating such specific poison to his patient. During the past spring an epidemic of erysipelas spread over this district and several deaths from it, as well as from puerperal fever, were reported. One woman was confined in the same room where slept a child suffering from suppurating erysipelas of the head and face. She died from puerperal fever six days after confinement. The child was removed as soon as the physician arrived, but too late to protect the woman, who was already through with her labor and had flowed some before the doctor reached her.

I continued my midwifery practice as usual, although I was at the time in daily attendance on cases of erysipelas, some of which were of the phlegmonous variety, which is said to be more virulent than the simple cutaneous non-suppurating type. I adopted a rigid system of disinfection daily, taking a general bath after returning from my erysipelas patients, sponging the body—especially the hair and whiskers—with a carbolic lotion, using carbolic acid freely in the lying-in room; never wearing clothes that had been exposed to any infectious diseases. I handled my patients as little as possible, and used as a lubricant, carbolized tallow softened with turpentine. I observed in two cases where there was slight laceration, and where I was extremely anxious to guard against septic absorption, keeping the raw surface covered by a piece of lint soaked in a 2 % solution of carbolic acid and using a carbolized vaginal douche three times a day, that after forty-eight hours the patients suffered retention of urine; using the

catheter and discontinuing the use of carbolic acid for a couple of days, had the effect of restoring the normal function of the bladder, which I believe was paralyzed by absorption of the acid. My precautions may have been overdrawn, but I had the satisfaction of seeing all my patients do well, not one of the twelve I attended during the epidemic manifesting any symptoms of septic poisoning.

## THE GROWTH OF A PROFESSION.

*Abstract of the address delivered before the Canada Medical Association, in Chatham, Ontario.*

BY WILLIAM OSLER, M.D., M.R.C.P., LOND.

President of the Association, Professor of Clinical Medicine in the University of Pennsylvania, Philadelphia.

The incorporated body of the profession in each province of Canada is variously known as the "College of Physicians and Surgeons," the "Medical Council," or the "Medical Board," and, as you are all well aware, by the Act of Confederation, each province is left to regulate its own educational affairs. Within the past ten or twelve years, so many important changes have been effected, particularly in the older provinces of Ontario and Quebec, that the boards are gradually approaching a state of efficiency.

As regards education, the ideal board should perform the following duties: 1st. Test the fitness of young men to enter upon the study of medicine; 2d. Order the curriculum in a manner best suited to the country and the requirements of modern medicine; and, 3d. Control absolutely the examinations for the license to practise. Upon each of these points I propose to make a few remarks, referring particularly to existing conditions:

1. Preliminary education and matriculation. In most of the provinces a thoroughly satisfactory system prevails, and a young man, before entering upon the study of medicine, must give evidence that his general education is of such a nature as will enable him to pursue intelligently the study of a learned profession. A board should control its own matriculation examination, and should accept no other. It is directly responsible to the profession that no incompetent person shall be admitted to study. The check comes lighter to a young man, and is more easily borne at this time

than later in his career. The examiners should be independent persons, engaged in general teaching and there should be at least three or four. No one man can conduct a preliminary examination with entire satisfaction. The organization of the board of matriculation examiners in Quebec should serve as a model for all the other provinces. It was a decidedly retrograde step when the medical council of this province relegated the entrance examination to other hands. And the acceptance of the intermediate High School certificate is not without its disadvantages. Throughout Canada the subjects for matriculation have always closely followed those recommended by the British Medical Council, and embrace the elements of a good general education, with a fair amount of Latin. To these special subjects have lately been added Natural Philosophy, Chemistry and Botany (optional). The student has had in the past several difficulties to contend with which should be removed. He has had to pass in some cases two examinations: one before the board of his province, and the other before the university at which he wishes to take his degree. Now the matriculation examination of the boards should be placed on such a level, and conducted in such a way, that any university could consistently accept it in lieu of its own, and if it was universally recognized by the profession, by teachers of high schools, and by the candidates, that there was but one portal of admission to the study of medicine, and that through the medical board by means of its authorized examiners, a great deal of trouble and annoyance would be prevented. Again, in the interests of the student, the greatest care should be exercised in the selection by the examiners of subjects which the candidates will find taught in the advanced classes of the high schools. Similar books to those read for other matriculations should as far as possible be chosen.

2. The regulation of the curriculum. The general profession, through its delegates, has an incontrovertible right to regulate and frame the curriculum of study which men shall follow who aspire to join its ranks. The governments allow this right and have empowered the Boards to frame such measures as they see fit. In the exercise of this function there has been a little friction in the past, and in no one of their duties will the Boards of the various provinces require to proceed with

greater circumspection in the future. That there has been a good deal of tinkering, and not always of a satisfactory kind, is a complaint frequently made by schoolmen. That there has been very little and that the results have not been bad, will, I think, be the verdict of any one who looks into the matter fully. The curriculum is at present in a transition stage, and we must expect in the next few years to see important changes, but into these I do not propose to go in detail. One thing is clear, that the Boards and the teaching bodies must act in concert—in the interest of the student and of the profession harmonious action must be arranged. In this country the students of all classes seek the degree as well as the license and are not, as the majority are in Great Britain, satisfied with the latter. Hence the imperative need of a certain uniformity in the requirements of the boards of the universities. The teachers cannot possibly arrange the instruction on diverse plans. The duty of the Board is to lay down a minimum curriculum to which every student shall conform, and which the schools can easily carry out. The university requirements, while as much higher as the authorities choose to exact, should be laid down in the same lines, so that a student could easily proceed in his studies for the one or the other without inconvenience, and the teachers prepare a man for either examination without needless repetitions.

Among important questions which await settlement in some of the Provinces are the strict enforcement of the four years of study and the advisability of prolonging the session to nine months, or, what amounts to the same thing, making the summer session compulsory. The plan of allowing a student to pass one of his four years of study with a physician should be done away with at as early a date as possible. For two reasons: in the first place, it is, in a majority of instances, a farce, and we find on enquiry that the student has been pursuing his usual avocation, and perhaps going to a doctor's office in the evening: it is certainly not the equivalent of a session at college. If allowed at all, it should not be the first year, but the third, as permitted in the province of Quebec, for then a student is in a position to obtain really valuable instruction in practical medicine and surgery from his preceptor. I was surprised a few years ago, on obtaining the statistics from the registrar of one

of the boards, to find how many men there were who passed on the three sessions. In this matter, the boards should not be behind the leading universities, which no longer recognize the year with a physician as the equivalent of a session. And, in the second place, the change should be made in the interests of the schools themselves. On no possible scheme can you arrange a satisfactory three-session course. Either a man pays too much attention to his primary subjects in the first two sessions and leaves the important final branches for one short session, or he tries in his second session to work hard at both and ends in a muddled condition which unfits him for either. The prolongation of the session to nine months, as now exists in some of the schools in the Province of Quebec, must ultimately come in all the colleges. How the foolish habit arose of giving six months' vacation we need not stop to inquire—the folly of it is too evident to need remark; and we can safely predict that within ten years the nine months' course will be universal, either as a continuous session, as at Laval University, or by making the now optional summer session compulsory.

3. The control of the licensing power is the most important function of the medical boards. A uniform system has not yet been adopted in all the provinces. In too many the possession of a degree, obtained after a proper course of study, still entitles the holder to the license, all others having to submit to examination. In the Province of Ontario the most advanced position has been reached, and the one road to registration is through the examination conducted by a board appointed by the medical council. To this the other provinces must ultimately come. It is what the profession in Great Britain has been striving after for years, and so far striving in vain against the power of corporations and vested interests. In the Province of Quebec the medical board accepts degrees from the local universities to which it sends assessors—after the manner of the British Medical Council, who report on the nature of the examinations. Others than the holders of such degrees must submit to examination. Although this method has not worked badly, it is but a make-shift, and must finally be replaced by a central board of examiners, who shall test the qualifications of all candidates. Unfortunately the prevalent conditions of that province are such that

dual boards will be needed, one for the French and one for the English.

In carrying out the details of a central examining board, there are inevitable difficulties which at first cause worry and discontent, but, with patience and mutual forbearance, gradually vanish. The choice of suitable examiners is a delicate matter, and one on which the schoolmen are apt to air grievances more or less just. They certainly should not be selected at random from the members of the council. A few years ago a friend of mine was nominated examiner in chemistry at the Quebec Board. He was a remarkably able practitioner, but with a very indistinct and hazy knowledge of chemistry, and it was hard to say who was most uneasy at the examination, Dr——— or the students. Teachers in the schools have good grounds for complaint when the Boards select as examiner on special subjects—such as anatomy, chemistry, physiology, and pathology—men who have been for years in active practice without any possibility of keeping their own knowledge on these subjects fresh and practical, and who to “brush up” require to work as hard, may be, as the poor candidates. With the more practical branches these difficulties do not exist, and the Councils have a wide field for selection. Where special technical knowledge is needed, it would be preferable even to override the law which forbids the selection by the Boards of any teacher as an examiner on his own subject. For the “Staats Examen,” in Germany, the professors in different departments are usually chosen by the government to conduct the examination in their special branches. The point is one to which the Boards should attend carefully in the future. They lose the respect of the profession and of the students in nominating as examiners men without special qualifications in certain fields.

The examinations for the license should be made in all respects as practical as possible, but to do this a Provincial Board must possess its own building and appliances, and make arrangements with hospital authorities to have free access to a sufficient number of patients. As the work is done primarily in the interests of the public, it is clearly the duty of the Legislatures to assist in making suitable provision, and it seems probable that Ontario, the first to set the example of a one-portal licensing system, will also be the first to have a

local habitation worthy of her incorporated profession. Such a building should contain the paraphernalia necessary for examination purposes. The division into a primary and a final examination, as at present made in most of our universities, and at the Ontario Medical Council, seems the best arrangement. The former embracing anatomy, physiology, general and medical chemistry, and materia medica; the latter, the practical branches of medicine, surgery and midwifery. In practical details the "Staats Examen," of Germany, might in many particulars be followed.

A serious difficulty has been felt in conducting the examinations satisfactorily as regards time, place and rapidity. They should come off after the university examinations have been completed, and not, as now, immediately at the close of the session. More time could then be given, which will be necessary if the tests are to be made more practical. As the number of candidates increases, the the examiners on each branch should be doubled. One centre in each province should be chosen for the sittings of the Board, and in almost each instance this will be the chief town. To go to Quebec for one meeting and Montreal the next, as is the practice in the Province of Quebec, and to hold an examination in Kingston as well as in Toronto, are touching and tender tributes to age with which a harder generation must soon dispense. Very much more time must be hereafter given to those practical portions of the examinations which afford the only true test of a man's fitness to enter the profession. The day of theoretical examinations is over. An anomaly which has been the source of no little irritation results from our close connection with the mother country. Any registered practitioner of Great Britain under the present British act can claim registration in the colonies without further examination. After graduating, Canadian students are enabled to give the Board the slip by taking an English or Scotch qualification, and registering in Great Britain, when they return and are entered upon the register without further examination. In the past five years 378 men have registered in the Province of Ontario, and of these there were 93 Canadians, who did so on their British registration; that is to say, about one-fourth of the number have avoided the enactments of the Board by proceeding to Great Britain and passing at one of the Colleges. No

one can doubt that these 93 men were greatly benefited by the period of additional study and by contact with men of other schools and countries, but they would have been still more benefited if they had first conformed to the requirements of their own province, and aided the profession in maintaining regulations the benefits of which are universally recognized.

The fees demanded by the boards excite a good deal of grumbling on the part of students and practitioners. A sum of \$70 is charged by the Ontario Board for the three examinations, matriculation, primary, and final; and in Quebec the registration fee is \$20, and the matriculation \$10. It is the old story, those who are best treated often complain the most. In the matter of fees, the medical students of Canada are in too easy a position, and they must expect changes in the near future. While the expenses of conducting a medical school have quadrupled in the past twenty-five years, the fees have not increased ten per cent. The charges of the boards are just and reasonable, as well as necessary to meet expenses. The annual tax on physicians of \$1 in Ontario and \$2 in Quebec, is often spoken of as irksome, but surely it is a trifling contribution to the general welfare of the profession.

It seems extraordinary to outsiders that in a country like Canada, with scarcely five millions of inhabitants, there should be so many licensing boards, and a still greater anomaly, that a licentiate in one province cannot practise in another—that there should be no reciprocity. So it seemed also to many earnest minds a decade or so ago, when in this Association a strong attempt was made at several meetings to frame a Dominion Medical Bill. It failed, as will, I think, subsequent ones, should they be made. Only one remedy remains, the boards of the various provinces may in time so assimilate the curriculum and examinations that reciprocity may become possible, but this we cannot expect for some years. For certain purposes a Dominion Registration Bureau at Ottawa seems specially indicated; thus the surgeon of a Quebec regiment doing duty in Ontario would be practicing illegally, and in the marine the surgeons sailing in the passenger steamers must be registered in the province of the port from which the vessel sails. There would be great if not insuperable objections raised to any such bu-



reau, though it might be feasible to devise a plan for the military surgeons and those belonging to the mercantile marine.

I have dealt thus fully with the constitution and functions of the medical boards of the provinces, because I feel convinced that the safety of the profession rests with them. Of inestimable service in the past, their work in the future will be even more beneficent. Do arouse to a sense of your professional advantages. Where else do the medical men of a country enjoy the rights of conducting their own affairs in their own parliament? Look at Great Britain, where our mighty sister Association, with all her influence, and backed by eleven thousand members, could not force the principle of professional representation into the last medical bill, and at the best was only able to secure three or four members from the profession at large. Rest content when in each Province of this Dominion you have (1) an elective representative assembly (medical board, council, or college), with members from each teaching body; (2) absolute control of preliminary qualifications, curriculum, and examinations for the license to practise; (3) appropriate accommodation for the meetings of the boards, for the conducting of examinations, and for preservation of the local and general archives of the profession. The full development of the Acts of 1788 and 1815 will not be reached until these things are accomplished. The first two you have already won in a majority of the Provinces, the last will perhaps be the most difficult of accomplishment; but I feel confident that the day is not distant when in the capital of each province the incorporated profession will have a stately Æsculapian temple worthy the traditions and aspirations of our high calling.

#### CASE OF NEURALGIA OF THE TRIGEMINAL NERVE.\*

BY T. OVENS, M.D., ETC., ARKONA, ONT.

MR. CHAIRMAN,—I shall not weary you with a description of this affection in general, nor shall I attempt to say anything of its pathology, because in any of our works on the diseases of the nervous system you can read a better description of the malady than I could give you in this paper, but

unfortunately, none of our authors give us an adequate knowledge of the pathology of this terrible disease. What I purpose doing, is to bring my patient before you, and to describe his case in particular.

The patient is now twenty-one years of age, a beekeeper by occupation, having always lived in the country in a locality free from malaria and containing good water in abundance. His parents, brothers and sisters are living. No neuralgia, insanity, epilepsy, syphilis, cancer, phthisis, nor any other disease in the family. When about eight years of age he fell from the scaffolding to the barn floor, a height of about fourteen feet; was unconscious for some hours; blood flowed freely from the mouth, nose and ears; made a good recovery.

Was in good health till the spring of 1879, when he complained of severe pain in right upper jaw; the extraction of a carious tooth relieved the suffering for a few weeks; the pain again returned, several teeth were extracted but without mitigating its severity in the least. From that time till the middle of April of the present year, the patient suffered terribly. Each autumn, winter and spring the pain seemed to be more atrocious than it was the preceding year. During the warm weather the pain was not nearly so severe, but never entirely ceased. The patient was under treatment during all this time by different physicians.

On the first of February of this year, he consulted me. He had just returned from a three months' sojourn in Quebec, whither he had gone for treatment and change of scene. At that time the pain came on every five or ten minutes, lasting from half a minute to a minute; it was of a burning, boring, lancinating character, darting lightning-like along the three branches of the trigeminal nerve on right side of the head, in lower jaw, upper jaw, upper lip, brow and right side of forehead.

The patient was entirely free from pain during the intervals between the paroxysms. Excessively tender points would develop during a paroxysm, and continue throughout the duration of the pain. These points corresponded to the position of the mental, infraorbital and supraorbital foramina, inner angle of eye, side of nose and other places. At the close of a paroxysm, tears would flow from the right eye, mucus from the nose and water from the

\* Read before the Ontario Medical Association, in London, June, '85.

mouth, causing an eczema to develop on the right cheek. Pulse varied from 100 to 120; temperature from 99 to 100.

*Treatment*.—I tried all the more important drugs recommended by the best writers, as morphia, quinia, arsenic, iron, pot. iodide, cannabis indica, gelsemium, chloroform, aconitine, etc., etc. Of drugs, the only ones that relieved the pain were aconitine and morphine. Chloroform was the only agent which would prevent a paroxysm. Aconitine given in  $\frac{1}{100}$  gr. doses till the physiological effect of the drug was produced, would mitigate the severity of the paroxysms. A grain of morphia injected hypodermically would not prevent the occurrence of a paroxysm, but would lessen its intensity. Chloroform would prevent the paroxysms for from three to six hours, and thereby give the patient sleep, and was by far the best remedy tried. In April, a discharge of pus occurred from right ear, and continued for a month. As the discharge continued, the pain gradually lessened, and finally ceased altogether.

As to the cause of the neuralgia, it was probably due to caries of the petrous portion of the temporal bone or periostitis causing pressure on the Casserian ganglion.

## ARTIFICIAL LACTATION, IN OVARIAN AND UTERINE DISEASES.

BY JAMES STIMSON, M.D., PLUM CREEK, NEB.

Marriage is the Divine institution in which the Divine purpose of child-bearing is carried out. To marry and to bear children is the normal lot of woman. Happy the woman who becomes a wife! Happier the wife who becomes a mother. Thrice unhappy the childless wife—the “barren woman who has no blessings of the breasts and of the womb.” ’Tis this unsatisfied, unhappy woman who seeks the physician, fondly hoping his skill will avail to remove the cause of her reproach, and secure the fruition of her desires. In the interest of such, these thoughts are offered to the profession.

Three great steps, in regular sequence, occur in normal child-bearing—viz: Menstruation, uterogestation and lactation. Three sets of organs perform these functions, viz: Ovaries, uterus and mammae. A trio of functions founded on a tripod of organs. The ovaries furnish a germ, the uterus

carries a crescent burden, and the breasts nourish a new being. This cycle of events recurs, with varying intervals, during the functional life of the ovaries of a fertile woman. The ovaries contribute the ovum; that impregnated, they rest. The uterus receives its treasure, retains it during the earlier stages of development, casts it for further nutrition and development upon the breasts, returns to its former proportions, and rests. The breasts receive the babe for a variable time, furnish it with food specially adapted to its needs, then cease their function, and rest. So, to each of these sets of organs, in this procession of events, there comes alternately, a season of activity and a period of repose. Such the events, their order and effects in normal child-bearing. But, unhappily, all wives are not child-bearers. In the childless woman, but one of the three essential child-bearing steps are taken. The ovaries only, perform their function. The uterus fails to afford “fruit.” That “child-link” missing, the chain of child-bearing events is broken, and the breasts abide functionless, at rest. Barrenness is the unbridged span between the ovaries and the breasts.

Returning to child-bearing, we find that *rest* is a factor in the healthy condition of each, in turn, of the organs concerned in its normal course, Contrasting sterility with normal child-bearing, we find that the chain of alternate action and repose in each set of organs is broken, the rhythm of events interrupted. Two sets of organs are functionally active—that constantly—and one set of organs does nothing. Two sets of organs have no rest, (so to speak,) one has no functional activity. The question now occurs, “Can the inactive organs, the breasts, be artificially excited to perform their function in a sustained manner, and, if so, will that functional activity of the breasts, so induced and sustained, have the effect of lulling to rest the active organs, the ovaries and the uterus?” In other words, “Can artificial lactation be induced, continued and made useful in treating ovarian and uterine disease, sterility, etc., by reason of its causing an arrest of menstruation, and so affording needed rest to the diseased organs?”

It is a fact that sucking the breasts causes uterine contractions. It is a fact that during lactation menstruation is absent. May we not infer from these facts that a bond of vital relationship exists between all the three sets of organs directly con-

cerned in child-bearing? But who can tell precisely, what the vital relations of the ovaries, uterus and mammae are, each to the other, or in what manner or to what extent the functional activity of any one of them affects the organic, vital condition of the others? In the child-bearing woman, the ovaries, uterus and mammae, each in turn, has a term of rest. In the sterile woman the ever active ovaries and uterus need rest. Can it be procured for them by arrest of menstruation, the result of artificially induced lactation? If so, the sterile patient may well rejoice over the brighter prospects for her "keeping house." If so, the gynaecologist will rejoice over his power to substitute one function for another, for thus he will get rid of the hindrances caused by the monthly menstrual nixus, and secure greater facility and ability to completely cure his patient. Given the substitution of functional activity of the breasts for functional activity of the ovaries, more happy results of treatment of "female diseases" will gladden the hearts of patients and physicians.

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### Correspondence.

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#### FILARIA SANGUINIS HOMINUM.

To the Editor of the CANADA LANCET.

SIR,—In your October issue there appears some correspondence on the very interesting subject of Filaria from Dr. E. A. Hall, of Glamis, and inviting additional information with regard to it. With your kind permission I will endeavor to add a few of the points desired, without attempting to exhaust what is already known.

*Filaria Sanguinis Hominum* is associated with, and generally considered now to be the etiological factor in chylous urine, some forms of hæmaturia, and nævoid elephantiasis. The knowledge we possess is of very recent date, as fifteen years ago it was entirely unknown. Dr. Lewis, an Army Surgeon, at Calcutta, was the first to discover in 1870 the embryo form of filaria in chylous urine. In 1872, he made a further discovery of the same species of filaria in the blood taken from the finger of a Hindoo patient. There are two forms of the hæmatozoon, viz: the adult and embryo. The former measures about three to four inches long and about the thickness of a hair, is supposed to dwell in the lymphatic system, and from there

pour forth its young, but has been found in hydroceles and lymphatic abscesses. The latter measures about  $\frac{1}{10}$  to  $\frac{1}{5}$  of an inch in length, and of the diameter of a red corpuscle, thus enabling it to pass wherever blood can go, even through the finest capillaries. It is enclosed in a transparent sheath or pellicle, and found chiefly in the blood and urine. The majority of cases reported have been residents of warm countries, but four or five have been recorded as originally from Europe. Of these, Dr. Beale mentions one as never being out of Norfolk, and Dr. Roberts another who had always lived in Lancashire.

One of the most peculiar and interesting features in connection with the habits of this parasite, is the regular periodicity with which it makes its appearance in the blood. Dr. Stephen Mackenzie, in 1881, before the pathological society in London, exhibited a soldier, born in India, suffering from chyluria and hæmaturia, accompanied by filaria. The blood was examined every three hours with the following results. The filaria were far more plentiful or only found at night; they usually appeared about 9 p.m., reached the greatest number at midnight, and entirely disappeared by 9 in the morning. Experiments were made with this patient, to see if this periodicity could be changed, and strange to say, when the time for sleep was reversed, by making the patient sit up all night, the filaria were more numerous in the daytime.

Dr. Manson, of Amoy, from whose observations, the profession has reaped much of interest on this subject, has recently been fortunate enough to discover, that the mosquito, is an intermediary host. He has satisfied himself, that the proboscis of the mosquito enters the capillaries, and the filaria are withdrawn and probably deposited in water along with the larvæ of that insect, hence to the human subject and so on.

That the filaria produces hæmaturia and chyluria, there cannot be the slightest doubt, but how, is not clearly established. It involves too many theories for a letter of this kind. The most probable is the mechanical one. It is extremely likely that the embryo ultimately casts off this translucent sac or sheath in which it is enveloped, becoming then possessed of boring propensities, perforates the capillaries and lymphatic vessels, thus producing those symptoms which almost invariably accompany their presence.

I have no doubt that Dr. Hall possesses a very valuable, rare and interesting patient. I am sorry he did not examine the blood and give us the patient's former history and residence. I hope he will do so yet, at the same time test their periodical appearance in the blood, and give the result in your esteemed journal. I have examined most of the Canadian medical literature of the last fifteen years, and fail to find one case recorded, still I do not see why cases should not occur in Canada, as well as in Norfolk or Lancashire. At the recent meeting held in Chatham, of the Dominion Medical Association, Dr. Bethune, of Wingham, exhibited a parasite three or four inches long, which he obtained from an abscess in the thigh, but whether it belonged to the filarida family or not, was not decided. Dr. Osler, the worthy president, and able pathologist, took possession of it and promised his verdict at a future day.

As to treatment. I will give Dr. Lewis' own words, "This has proved extremely unsatisfactory in almost all cases recorded. Iodide of potash has been tried in large doses, and in some cases appears to have been beneficial. In others the tincture of iron has seemed to be more successful. Perhaps the most satisfactory results, are those which have followed the administration of large doses of gallic acid.

Yours, etc., WILLIAM GRAHAM,  
Brussels, Oct. 6th, 1885.

To the Editor of the CANADA LANCET.

SIR,—I have read carefully, and with a good deal of interest, an article in the Sept. No. of the LANCET, headed "Meddlesome Midwifery." With the general tenor of the article I heartily agree; though some of the statements do not entirely accord with conclusions drawn from my practice.

The first is the following clause: "But we would all prefer that somebody else's wife or sister should be the subject of all doubtful practices." This, I think, would hardly be in keeping with the rule given in Matthew vii. 12, which, I presume, most medical men will admit to be binding. We certainly should not encourage doubtful practices even on somebody else's wife or sister. But what particularly interested me was your pen pictures of scientific and unscientific practitioners of meddlesome midwifery. I take it that this applies to registered practitioners, who, if they lack the

necessary qualifications to practice, are as much sinned against as sinners, by the Medical Council, which has taken upon itself the task of protecting the community from improperly educated pretenders. If such still exist it is a proof that our Council has, at least in some measure, failed in its mission, in giving a license to them.

While I look upon your scientific bungler as a dangerous character so full of himself and his own importance, that he is unlikely to improve, I feel that I can safely predict, at least, a respectable future for the other, "Conscious of his lack of skill but desirous of earning his fee." This consciousness, and this desire which all should possess, will, if properly used, be the making of him. The former will make him careful and at the same time prompt him to read and so post himself where most deficient; he will also watch his cases closely and as his years increase so will his knowledge. His desire to earn his fee is an indication of honesty, which of itself would make him more to be relied upon, and is very different from a desire which we too often see, of finding an excuse for making visits that are of no real use to the patient simply from a desire to charge fees. As to his too frequent examinations I think he will soon get over that, as but few women will be found to submit to it when it gives them pain. It may, as you suggest, produce a tendency to laceration, though I have never seen one clearly traceable to that cause, but I have often found the soft parts dry and tender, where no examinations had been made and yet the labor terminated without any appreciable laceration.

As to your scientific bungler, did he confine himself, in his use of chloroform, to a small quantity, sufficient to mitigate the pains as the head is distending the perineum, I presume no damage would be done, in most cases, and if it did delay the labor a little without materially adding to the patient's sufferings so much the better, as it would give the parts more time to stretch and so render laceration less likely. But what I have known such bunglers do is, under the pretext of giving chloroform to relieve pain, to put the patient profoundly under its influence, and then without the knowledge of either the patient or friends, put on the forceps and drag the child forth, producing laceration of the perineum, followed in many instances by puerperal fever or septicaemia.

As to the use of antiseptics, like any other therapeutic agent, they should of course only be used when required, but then in such a manner as to thoroughly cleanse and disinfect the parts requiring it. But where the patient is kept clean, and at rest, on a clean bed, with fresh air and frequent change of napkins, they will not often be required.

Yours respectfully,

R. WHITEMAN.

Shakespeare, Oct. 14, '85.

To the Editor of the CANADA LANCET.

SIR,—I send you the following unusual case for insertion in the LANCET :

M. L. aged 82 years, had for several years been troubled with pain and distress on making water. One day he noticed a hair protruding from the penis about an inch. He pulled at it and withdrew it about 4 inches, when there appeared to be something preventing its coming, and on pulling harder, it caused pain in the region of the left kidney, as if something were tearing the flesh, so he called his wife, an old lady aged 76 years (now) and she assisted him. After about twenty minutes, they succeeded in removing it without breaking. It was 24 inches long, of a dark brown color, with a bulb at the end like a hair from the head. He says he felt greatly relieved afterwards from the peculiar feelings he used to labor under. The hair was shown me, and I have the utmost confidence in the correctness of the statement, which was corroborated by the old lady, who assisted in its removal, as well as by the son and others of the family. A similar case (or cases) may have been met by others, but I have never read of a recorded one.

Yours very sincerely,

R. W. CLARK.

Hastings, Oct. 16, '85.

P. S.—The above case is not more singular than, —a potato bug which, a son of mine, met with in an egg, last summer, after it was cooked for breakfast.

## THE USE OF THE FORCEPS.

To the Editor of the CANADA LANCET.

SIR,—There was an article in your last January number by Dr. Sweringer, of Ind., advising practitioners always to "carry their forceps with them to every labor case." I cannot agree with the Doctor in this, for the proportion of cases really

requiring instrumental aid are so few, that to carry them always entails a deal of unnecessary trouble. I would except a case a long distance off. The forceps are very often used unnecessarily. In a practice of fifty-five years I have not used them a dozen times, and in that length of time, I have had but two fatal cases, and those from puerperal fever and peritonitis.

The forceps are sometimes used to save time, sometimes to gain a little notoriety, sometimes for the double fee, and sometimes from ignorance. I remember a case that occurred a few years since, where the doctor in charge, had been two nights and off and on for two days in attendance on the woman. He said that he had a very troublesome case, and was going to use instruments that night (the third night) but asked me to visit with him before so doing. I went, and found the woman was not in labor at all, and had not been—simply false labor pains, which a full dose of laudanum checked, I told him she would not be confined for a week at the least. Ten days afterwards she was delivered of a fine child without the forceps. Therefore, looking at it from my point of view, I say that carrying them all the time to every case is unnecessary; for if not too far off you have always time to send for them, except in a case of convulsions, which are rare. Dr. Thatcher, Professor of Midwifery, in Edinburgh, laid it down as a rule, "to allow seventeen hours for a natural labor, before having recourse to instruments, except in cases of deformity.

I remain, etc..

R. W. CLARK.

Hastings, Ont., Sept. 8th. 1885.

## Reports of Societies.

### MEDICO-CHIRURGICAL SOCIETY. MONTREAL.

The annual meeting was held on the 9th ult., Dr. Roddick in the chair.

Dr. Trenholme exhibited three pathological specimens. The first was a parovarian cyst, removed from a patient from Shawville, Que., 42 years of age, 9 years married, and no children. Patient was of spare habit, nervous, and had suffered for 16 years. Her trouble began in the bladder, as she supposed, accompanied by pains in the back, inability to sit,

irregularity of menses, and insomnia. Has had no menstrual flow for last 6 months. At the present time her trouble is chiefly confined to the regions of the back and over the womb. Examination per vaginam showed the presence of a large tumor filling the brim, occupying true and false pelvis. It was in the median line, very dense to the touch, and uniform over surface. On the left antero-lateral aspect a small tumor was detected; this was supposed to be the left ovary, and is seen to be such in the specimen now passed round. The cavity of the uterus was three inches deep, and this organ was carried on the face of the tumor, above the brim of the pelvis. The diagnosis was first ovarian cyst, but later, fibroid of the uterus, owing to the slow growth and hardness of the tumor, immobility and position of the uterus. On 12th August, 1885, Dr. T., assisted by Drs. Kennedy (who had also examined the patient, and regarded the tumor as fibroid), Cameron, Perrigo, and Reddy, made an abdominal section to the extent of three inches, and removed the cyst in the usual way. Fitch's trocar was used, but the Dr. was not so well satisfied with it as the Well's trocar. The points requiring tying were all secured by the Dr.'s favorite ligature, No. 20 shoemaker's white thread. The incision was closed by three deep silver sutures, and superficial horse-hair sutures. The only serious after-trouble arose from irritation of the bladder; and, though rather too soon, she returned to her father's home, Iroquois, just three weeks and one day after the operation.

The second specimen was a cancerous uterus, removed from a lady 42 years old, who had been suffering for some time past, but only consulted Dr. T. about herself in August last. Upon examination it was found that the disease had invaded all the os, lower part of the neck, and the vagina on the left side to the extent of about half an inch. The uterus was moveable, and depth of cavity three inches. Hoping that the disease was confined chiefly to the parts seen to be affected, and that infiltration of the broad ligaments had not yet taken place, Dr. T., at the urgent and repeated requests of the patient, thought it right to give her the possible benefit of short respite from her sufferings by removing the uterus. On 20th August last, assisted by Drs. Kennedy (who, also, thought it right to give her a chance of temporary relief), Perrigo, and Cameron, Dr. T. cut through

the posterior wall of the vagina, brought down the fundus, then tied the right broad ligament in small segments, and divided the enclosed tissues with the scissors; the same procedure was found to be impossible on the left side, on account of the infiltrated state of the tissues. After separating the uterus from its anterior attachments, the left ligament had to be divided guided only by the sense of touch, and the entire organ was removed. Very little hemorrhage followed the operation, or the scooping out of some cancerous masses with Thomas' spoon. It is now seven weeks and one day since the operation, and though the opening into the peritoneal cavity could not be closed, and there was presentation of the intestines at the upper part of the original incision, yet the patient has so far recovered that she is able to walk round her room, and intends soon to return home. She has suffered no pain from the operation; in fact says she has no pain, and feels well. The chief cause of her weakness has been the large and constant flow from the peritoneal cavity, but now this drain is almost stopped.

In the discussion which followed, Dr. T. said he would not perform the operation again under similar circumstances. *Where the disease was confined to the uterus*, he would consider the operation a justifiable one.

The third specimen was a fibroid uterus, removed from the patient, who was the *first* person ever spayed (in 1876), for the arrest of uterine hemorrhage. The removal of the ovaries at that time gave the patient a new lease of a life that was then fast drawing to a close. As has been stated by me upon several occasions, this patient had irregular hemorrhages, seldom of any extent, and without the periodicity or appearances of the menstrual flow. In March last she was in good health, but over-fatigue brought on severe uterine congestion, accompanied by severe nervous derangement, that threatened to end her life. These attacks, very curiously, recurred every nine days and lasted for nine days, during which time she was unable to take solid food, lost flesh and strength, and suffered with a numbness, amounting almost to paralysis of the right arm and side; loss of sight, irregular and rapid action of the heart. These attacks were becoming more and more severe, when, in the hope of obtaining relief, she came under my care. The uterus was low down in the pelvis and about the

size of a foetal head, the bulk of the mass being rather to the left of the uterine canal, which was almost five inches deep. As the patient was in a wretched condition of health, the operation was delayed for a week, when, upon 24th Sept., the tumor and uterus were removed by abdominal section. Strong adhesions existed throughout, especially with the bladder, which was incised to the extent of about half an inch. The broad ligaments were tied in segments, and separated as far as the neck, when a wire ecraseur was applied, and tightened just enough to prevent hemorrhage. The tumor was removed by a V shaped incision, and the cut surfaces brought together by a double running suture (silk). The wound in the bladder was brought together by the same suture. The abdominal wound was coapted by three deep silver and a number of superficial horse-hair sutures. A catheter was kept in the bladder for five days, after which she passed her urine without trouble. It is now 16 days since the operation, and both temperature and pulse have been almost normal throughout.

In the discussion which followed nothing new was elicited, and the Society then proceeded to the election of officers. On account of the illness of Dr. Roddick last winter, and his absence in the North West Territory during the summer, it was felt to be but an act of justice to re-elect him President. *Vice-Presidents*, Drs. J. C. Cameron and Geo. Wilkins; *Treasurer*, Dr. Perrigo; *Secretary*, Dr. Gurd; *Council*, Drs. Kennedy, Geo. Ross, and Roddick.

Before the meeting adjourned, the question of the treatment of the small-pox patients and the management of the Hospital was fully discussed.

#### HAMILTON MEDICAL AND SURGICAL SOCIETY.

At the regular meeting in September, Dr. Case, senior, presided. Dr. Malloch exhibited a pathological specimen, with the following history. He had performed abdominal section in a case of peritonitis with symptoms of obstruction of the bowels and a history of previous attacks of colic. The colon was so much distended that it could not be returned. To relieve this distension, an opening was made with a scalpel, of its own width simply, and the gas pressed out. The wound was then

closed with interrupted sutures of the finest catgut. The patient only survived the operation 47 hours. At the autopsy it was with great difficulty that the site of the wound could be found, the union was so good. There were no signs of inflammation to be found, and no adhesions were present about the wounded intestine.

The October meeting was presided over by Dr. White, the President. Dr. McCargow showed the larynx of a man who was in the City Hospital for but a short time. His history was as follows:—He was 28 years of age, had been working on the railway, and caught cold. When admitted to the Hospital was much emaciated, had a bad cold, enlarged glands, and was unable to swallow. He was ill only six months. Family history was good, there was no record of either phthisis or syphilis. Post mortem, as seen by the members, there was ulceration and partial destruction of the epiglottis. The lungs, which were unfortunately mislaid, were full of miliary tubercles. In the left apex there was a cavity the size of an almond, and the lung was adherent. There was also softening in the right apex. The other organs were normal. Dr. A. Woolverton had seen the patient during his lifetime, and noticed that he was specially anæmic and had the characteristic appearance, but not the physical signs especially, of tubercular trouble: but there was dulness of the left apex. Patient resembled more one with typhoid fever with a slight cough. Dr. Mullin recollected a case in the Hospital that was at first thought to be syphilitic laryngitis, as there was laryngeal trouble, and the patient was an old soldier. Dr. McCargow had seen suppurating kidney in similar cases. Dr. White remembered a case, taken for typhoid, where miliary tubercles were found in the lungs and kidneys, but no suppurating cavities or foci. Dr. McCargow then gave the history of two cases, he had seen in practice, of foreign bodies entering the larynx and being found in the right bronchus. The first case was that of an infant who was playing with some green coffee beans, and had some in its mouth; some one made the child cry; it was seized with an attack of coughing and strangling, and evidently, from the history, would likely have returns of the cough, and did. Acute bronchitis set in, tracheotomy was advised, but not permitted, and the child died in two days. Post mortem—three green coffee beans were found in the right



bronchus. The second case was that of a boy aged 7, who was running while holding a head of timothy in his mouth; he stumbled, and the head disappeared; he was seized with a fit of strangling, but rallied. A few days afterwards he was found to have pneumonia of the right apex. Active treatment was used, and the symptoms would yield, and then exacerbations would occur. A cause was sought by Dr. McCargow, such as an insect in the windpipe, but nothing of the sort was known of or remembered, till suppuration took place and some seeds of timothy came away; the sputa were rigidly examined twice a day; then the mother remembered about the head of timothy, which she had tried to remove at the time. A consultation was asked for, and the late Dr. Strange and Dr. Malloch went out to see the patient. The morning they went to Caledonia (where Dr. McCargow was then practicing), the boy coughed up a foreign body, apparently the head of timothy. But as there were signs of a cavity and gurgling was to be heard, the prognosis was bad, and there was not much improvement, though he continued to expel seeds. Two weeks after the consultation, the foreign body actually did come up, quite hard, and divested of seeds; it was two and a half inches long. The boy was carefully watched by his father, who however, by mistake, on one occasion gave him a dose of tinct. iodini. instead of tinct. opii., the fetor was then relieved but not the cough, so the dose was increased. The mistake was discovered, but on the suggestion of Dr. McCargow, the remedy was continued, and the boy recovered entirely.

Dr. Malloch referred to a case where a surgeon had operated in the dark and alone, and effectually, for the foreign body was loosened by the suppuration and escaped through the opening in the larynx. Dr. Malloch himself had had two cases lately: In one (a child), a piece of almond shell had entered the larynx, but operation failed to discover it; bronchitis set in, and the child died. In the second case, the foreign body was not discovered either, but the patient recovered without inflammation setting in. Dr. Rosebrugh related a case in which he had operated: A lad of 14 was attacked with suffocation every few minutes; the trachea was opened. During the operation he ceased breathing, and it was thought due to the chloroform, but probably was caused by the foreign body,

a piece of glass  $\frac{3}{4}$  in. long, which was removed when the trachea was opened, in this case from the left bronchus; the boy recovered all right. He thought inversion often helped the operation. Dr. Ryall related the case of a boy in whom a piece of nut had entered the larynx. He afterwards had asthmatic attacks, which lasted 9 months, and ceased one day after coughing up blood and the piece of nut, which was quite smooth. Dr. Stark remembered a case where a pear-shaped glass ornament had entered the larynx. The breathing was interfered with, sometimes on the left, sometimes on the right. Tracheotomy was performed, and on inversion the foreign body was removed. Dr. Mullin gave some particulars with reference to Dr. Malloch's second case: The boy was whistling with a whistle made of two pieces of tin,  $\frac{3}{8}$ th in. square, tied together. Although never found, it had been heard before the operation, and there had been attacks of laryngeal spasm. The boy has done well and the wound has healed. Dr. McCargow called attention to the fact that when a foreign body is loose there are always attacks of spasm.

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### Selected Articles.

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#### THE COMPARATIVE RESULTS OF OPERATIONS IN BELLEVUE HOSPITAL.

BY STEPHEN SMITH, M.D.,

Surgeon to Bellevue Hospital, New York.

As we drift with current events, we but imperfectly estimate the real advance which any art or science, with which we are daily familiar, has made within a limited period. It is only when we considerably pause and deliberately compare, in detail, past methods and results with those now practised and obtained, that we fully appreciate the vast changes which have so insidiously and imperceptibly taken place.

Perhaps there is no better place in which to test the progress of practical and operative surgery than the wards of Bellevue Hospital. This ancient institution has within its walls and its immediate environments all the conditions that in modern times are regarded as unhealthful and unsanitary. It was built between the years 1811-16, on the made lands of a cove of East River, without drainage, or adequate sewerage, and without regard to ventilation. During nearly three-fourths of a century the sluggish tides have ebbed and flowed through the sodden soil of its foundation, depositing far more filth than they have removed. Since its

occupation it has been used for a prison, an almshouse and a hospital. Its wards have, from time to time, been crowded with patients suffering from all forms of contagious and infectious diseases. It has been the common receptacle of typhus and typhoid fevers, small-pox, puerperal fever, cholera, and yellow fever. Although many changes have been made in its interior, yet the great and most serious defects of location and construction have remained unaltered, and may be regarded as permanent.

Bellevue may be regarded as having been a surgical hospital only since 1850, a period of about thirty-five years, during most of which period I have been personally very familiar with the practice in the several surgical divisions. The amount of surgery in the wards of Bellevue has been a gradual increase. With the removal of the New York Hospital, and during the long interval of its non-existence, the surgical practice of Bellevue became large and important, and has remained so to the present time. The surgeons of Bellevue have always ranked among the best in the city, and, as much of their practice in hospital has been public and clinical, it must be assumed that they have endeavored to the best of their ability to illustrate to their classes the highest type and best results of the science and art of surgery of their day. And yet the practice of surgery in Bellevue Hospital has, within the period mentioned, undergone so complete a revolution that one of the older surgeons would scarcely realize that he was in the same hospital where he had practised a decade ago. He would see, with horror, operations fearlessly performed that he had formerly regarded as without the pale of legitimate surgery. He would witness procedures in the after-treatment of operations which would seem to him to be fantastic, and even ludicrous. His astonishment would be extreme on finding that the first week passed without fever, and that no change in the dressings had been made. But, perhaps, the most remarkable feature of modern practice would be the rapid convalescence and final complete recovery without complication or exhaustion of ordinary operations, which formerly gave so much trouble and anxiety. To make more evident the change in practice, we may contrast in detail the several steps of operations in general, and of individual cases, the methods of treatment, and the results.

The older surgeons of Bellevue Hospital had practiced in the period anterior to the use of anesthetics. The most important general principle governing the operator was *celerity*—in order to limit as much as possible the amount of pain. Long after anesthetics came into general use surgeons dwelt with much emphasis upon the necessity of cultivating the habit of operating rapidly. The preparations for an operation were all made with reference to this one feature. So much did this

thought absorb the operator that he often became excited and annoyed by the delay. One surgeon, noted for the rapidity of his operations, was often seen, during the last moments of preparation for an amputation, to seize involuntarily the saw and move it rapidly, as if sawing a bone. Now, while every surgeon aims to diminish the period of anesthesia, mere haste at an operation is only mentioned to be condemned. No part of the elaborate preparations are designed to render the operation simply more rapid. One thought and purpose occupy the mind of the surgeon, and that is recovery without suppuration. To this end all his preparations are made, and the entire procedure is subordinated. Formerly the surgeon prepared his instruments only by keeping them free from rust, and giving them a fine edge. When he operated the instruments were taken from the case, and, without any cleaning, were so placed that he could most readily select the one required. During the operation he laid them down, or dropped them, and without cleaning applied them again to the wound. Now instruments are not only protected from rust and all soiling and kept sharp, but long before the operation they are placed in a carbolic solution, in order that any possible septic matter on them or their handles may be destroyed.

During the operation one assistant devotes himself entirely to the duty of handing the instruments to the operator, and of receiving them from him and at once submerging them in the disinfectant liquid. To avoid the possibility of laying an instrument down on an unclean surface, and then putting it in the wound soiled, towels wrung out of the antiseptic fluid are spread around the wound.

In preparing a part for an operation, an amputation, the surgeon used to do nothing farther than, perhaps, to have superfluous hair shaved off, and that, too, often without soap and water. Patients brought directly from the street or shop, with limbs begrimed with dirt and filth, were subjected to operations without bathing. Even when there was ample time for preparation little or no thought was given to the immediate condition of the part about to be incised. The accumulated secretions of the skin, and the dead epidermis, charged with poisonous animal matters, become part of the wound and its immediate surroundings. Through this layer of filth the surgeon passed his knife into the living tissues beneath, conveying to the deepest parts of the wound matters of untold septic virulence. In this simple failure to secure ordinary cleanliness of the surface, more wounds were poisoned and induced to suppurate than from any other cause. In the closure of the wound the filthy margins were often brought in direct contact with the cut surfaces, and thus the propagation of the germs of fermentation or putrefaction were implanted in a fertile soil. Now, the greatest pains

are taken to cleanse the part about to be operated upon. In addition to a general bath, the entire limb, including the hand or foot, is washed with soap and water, with a flesh-brush, and all the hairs are shaved cleanly from the part. This washing is followed by a douche of an antiseptic solution, and then all the parts adjacent to the wound are covered with towels, wrung out of bichloride solution.

The personal preparation of the surgeon and his assistants for the operation was limited to self-protection against soiling their clothes or person. No special thought was ever given to the condition of the hands and nails. The assistants came directly from other ward duties, their hands soiled with the thousand impure matters which they must handle, and with slight or no washing, engaged actively in the manipulations of the operation. Now the surgeon and his assistants take infinite pains with their hands. Soap and water and the flesh-brush are brought into active use, to be followed by a douche of bichloride solution. The nails, the most fertile source of filth in the body, are rendered scrupulously clean. Many will recall with a shudder the long claw-like nail of one surgeon, which penetrated, unwashed, every wound where he was present. Not only is no bystander invited to put his finger in the wound, but scarcely an attendant at Bellevue would allow such an intrusion.

The sponges of former times were universally believed to be the carriers of filth to the wounds, and yet little was done to purify them except to cleanse them in water. They may have been boiled at first to free them from sand, but they were not purified by any adequate means when first prepared, nor after their use in suppurating wounds. Now, the process of purification of sponges is elaborate in the extreme, and is so exact in details as to render them positively harmless in wounds.

The ordinary silk ligatures were formerly regarded as necessarily foreign bodies in wounds, and no care was taken of them to improve their condition. They were carried about in any convenient pocket, and at the operation the silk was cut of proper lengths, waxed, and then drawn through a buttonhole of an assistant, or laid on any convenient surface. Now, the ligature thread undergoes a long process of cleansing and disinfection at the hands of a chemist, and is then applied to a reel enclosed in a corked bottle filled with antiseptic fluid. From this bottle it is removed only as it is drawn out at the moment of using it. Considering the well-recognized fact that the ligature, as formerly used, was an intense irritant to wounds, it is not surprising that surgeons applied as few as possible. From time to time they resorted to other methods of closing arteries, as by torsion, or metallic wires, to avoid the use of silk. But all these devices bore no comparison to the simple and efficient antiseptic ligature of to day. Reeled off

from the bottle, clean, strong, and supple, the surgeon applies them without other limit than the complete suppression of hemorrhage.

Recognizing the silk ligature as an irritant, the surgeon always used to cut off but one end, and left the other depending from the wound, to be removed by traction when it had finally separated from the end of the vessel to which it had been applied. And well and faithfully did the ligature meet its indications, for, during the first week, the most critical period in the history of the wound, it did not fail to induce free, and often profuse, suppuration. But now, not only does the surgeon apply the ligature, but he cuts off both ends, and closes the wound as completely as if there was no foreign substance left between its surfaces. Nor is he disappointed. No suppuration follows the presence of the ligatures, and union takes place as promptly as if no ligatures had been used. The operation being completed in the shortest possible time, the operator concluded by exploring all parts of the wound with his unwashed fingers. If it was a hernia, he thrust his fingers as far into the abdominal cavity as possible, and explored it freely. This act completed it was a very common occurrence, also, for the surgeon to invite any bystander to examine the wound with his fingers, and sometimes several persons would avail themselves of the opportunity to improve their tactual sensibilities.

Many a wound that may possibly have escaped previous poisoning at the hands of the operator and his instruments, has received the final charge of septic matters from the dirty fingers of a casual looker-on. Now, the most scrupulous care is taken to protect the wound from injury, either at the hands of the surgeon or his assistants. Exploration is cautiously made with fingers cleansed and disinfected, and even that act is completed by a douche, over the entire surface examined, of the bichloride solution. If the finger of a bystander were introduced into the wound unwashed and undisinfected, the surgeon would regard the act as probably fatal to recovery without suppuration. Hence, no one is now invited by courtesy, or to obtain an opinion, to examine the wound by digital exploration unless they have made due preparation for the act.

In closing an ordinary wound the surgeon formerly took great pains to provide for the drainage of pus. The most dependent part of the wound was left open, and all the ligatures were drawn out at that point. The edges of the skin were brought into apposition by the interrupted suture, at intervals of half an inch, and the intervening skin was approximated by adhesive plaster. The suture and adhesive plaster were alike unprepared by any process that would relieve them of filth, and far too often both contained the germs of putrefaction. Now the surgeon employs sutures that, like the ligatures, have been relieved of all possible elements

of poisoning, both in their preparation and in the method of preserving them. In closing the wound he aims to avoid suppuration altogether, and to secure the immediate union of parts. The suture being non-irritating, he freely stitches together all the deeper structures first, wherever they can be approximated, and then the more superficial parts are brought into firm and exact apposition. Instead of the interrupted suture, which leaves the wound gaping at intervals, and necessitates the use of adhesive plaster, he employs the uninterrupted, or glover's suture, which closes the wound throughout, and relieves it of all necessity of additional support. Wherever there is liability of the collection of fluid from the immediate drainage of the surface of the wound, he inserts a drainage-tube, as a temporary expedient to prevent distension of the wound, and possible putrefaction. The advantage of this latter dressing over the former are apparent. No irritant is allowed to enter the wound. The suturing of the deeper structures brings into close and permanent apposition parts that formerly separated.

The continuous suture has great advantages over the interrupted suture, especially when it is taken deeply in the margins of the wound. It not only brings the surfaces into firm apposition at the points where it traverses the wound, but by whipping in the edges, in the parlance of the tailor, where it passes over the wound externally, it relieves us of the necessity of any additional supporting dressings. The advantages of this method of dressing, therefore, are great, and, indeed, vital, in the effort to secure immediate union.

The final dressing of the wound formerly was the adhesive plaster and the bandage for support and retention. The plaster was never rendered aseptic, and by its close relations to the wound was dangerous. The bandage was usually of unbleached muslin, and had no special cleansing or preparation for the wound. It may not have been harmful, but it added to the risks of infection. Now, the wound once closed, is protected from external infection by dusting the surfaces with iodoform. Then pads of disinfected materials, with iodoform sprinkled between the layers, are applied; sometimes over a large area around the wound, and in considerable numbers. The whole is retained by bandages of disinfected materials carefully preserved in a disinfected atmosphere. The addition of these external dressings, prepared with so much care, and adjusted with so much painstaking, has been very much criticised. It is possible that they are often unduly multiplied, but the results justify the faith which so many surgeons have in them.

In speaking of the closure of wounds, it should be stated that while the older surgeons did not close many wounds, as those of exsection, surgeons now close all such wounds. This difference in treatment is one of the most striking features in the comparison of the surgery of the present time

and that of a decade past. The former surgeon prepared the wound for suppuration, the later surgeons dressed it as for union without suppuration. Both uniformly realized their expectation.

If we follow the wounds treated by these two methods from the first to the last dressings, the contrast is remarkable. If the wound were large, on the second or third day the fever formerly began, announcing suppuration, and from this date, for weeks after, the dressings were changed daily, one two, or three times. The pus-basin, the irrigator, and the dressing-forceps were in constant demand. In many wounds the suppuration was so profuse that vessels were placed under them which received the continuous discharge. The fever generally ran high, with consequent exhaustion and depression of the patient. Septicæmia, as we now understand it, was the intermediary fever of that day, and was regarded as a usual, if not a necessary, sequel of all considerable operations. Following this fever, or rather insidiously engrafted upon it, were chills, fever, and profuse sweatings, now recognized as pyæmia, but then regarded as only another stage of surgical fever. Few indeed survived this fever: and in the diffused or metastatic abscesses revealed at the autopsy the surgeon discovered a cause of death quite beyond his power to prevent, control, or even comprehend. The vast change in the progress of operated cases during the past ten years can scarcely be realized. Surgical fever with all its disastrous variations, is, in practice, rare in Bellevue Hospital. Pus, as an outcome of surgical operations, is a thing of the past. On one occasion last winter, a teacher in one of the medical colleges sent to the wards of Bellevue for a specimen of pus for exhibition to his class, but none was to be found in the four surgical divisions of the hospital, although there was at that time an unusually large number of wounds and operated cases under active treatment. The wound is now dressed with no expectation that fever will rise, or that suppuration will occur, or that the dressings will require renewal on account of the presence of pus. The patient sleeps and eats well from the first, and the surgeon removes the dressing, often only to find the wound united. This remark is true, not only of incised wounds, but equally of wounds of amputation, excision, ligation of arteries, etc.

If now we turn from this review of the several stages of operations in general to particular operations, we find many curious instances of the remarkable progress of practical surgery in this hospital. It must be understood that in every operation all of the general precautionary measures already described are scrupulously taken and carried out, and, therefore, only special differences in treatment will be mentioned.

Compound fractures were formerly regarded as proper cases for amputation, if the local injury exceeded a single fracture, with a simple penetration

of the soft tissues. And even the simplest cases of compound fracture were reserved for treatment with many misgivings as to the result. The dictum of Hunter that "compound fractures commonly suppurate" was ever the guiding principle in the mind of the surgeon. If, therefore, the wound was extensive, or the bones comminuted, or a joint involved, amputation was the rule. If it were decided to endeavor to save the limb, the only measures adopted were sealing the external wound with some imperfect substance, and placing the limb in a comfortable position. The old fracture-box for the leg and the fenestrated gypsum bandage were the only measures employed. The fracture-box, with its bed of bran or sawdust, was regarded as a remarkable advance in the treatment of compound fractures of the tibia. Placed in the box, with the foot fixed to the foot-board, the wound was covered with bran, and suppuration allowed to go on *ad libitum* and *ad infinitum*. The contrivance had no merit whatever. On the contrary, it greatly aggravated the suppuration by fixing the lower fragment, while it allowed the upper fragment to move freely upon it every time the patient moved. The gypsum splint and bandage had the merit of keeping, or aiming to keep, both fragments at perfect rest. This method of treating compound fractures was a real step in advance, but it did not prevent suppuration in some measure. To-day compound fractures are welcomed to the wards of Bellevue as a class of cases which give the most satisfactory results.

Amputation is not thought of unless arteries and nerves are so far destroyed that death of the extremity must follow. Even when the wound involves a joint, the question of amputation is not more pressing. The treatment pursued is designed—1, to remove from the wound every particle of matter liable to injure the tissues and induce suppuration; 2, to place in fixed apposition all of the tissues composing the wound; 3, to cleanse and disinfect the wound, and protect it from becoming soiled during recovery; 4, to protect the wound from any movement of the parts entering into it while the process of repair is going on. The procedure, so far as concerns the wound, consists in freely exposing the injured parts by incision, removing all effusions of blood, shreds of injured tissue, fragments of bone, and then wiring the bones together so that fractured parts exactly fit each other, next stitching together all cut or torn tissues with prepared catgut thread, as far as they can be brought together; then the final closure of the wound, except where a drainage-tube may be inserted into a cavity of the deep parts; and finally, the external antiseptic dressings and a light bandage of plaster-of-Paris, and over all a wire gauze splint for suspension. This treatment of compound fractures is so uniformly successful that the surgeon has none of that care and anxiety after the

final dressings which formerly harassed him. If there should be symptoms indicating suppuration, the dressings are at once removed, and the source of the trouble searched out and destroyed.

Amputation wounds rarely, if ever, recovered at Bellevue, except after long-continued suppuration. From the smaller amputations patients recovered in due time, but often greatly enfeebled by the drain of suppuration. The larger amputations were terribly fatal. A resident surgeon once made the statement that a recovery after amputation of the thigh had not occurred in Bellevue Hospital "since the time that the memory of man runneth not to the contrary." Though this remark was not strictly true, it had a painful significance to the surgeons of that period. Suppuration with its sequelæ, septicæmia, pyæmic, and hectic fevers, was the scourge of the surgical wards. The open method of treatment of amputation wounds, advocated by Dr. James R. Wood, had only the merit of not confining the pus within the wounds, and of thus diminishing somewhat the liabilities of septicæmia and pyæmia. It did not prevent suppuration, the source of all the evil. The treatment consisted in closing the upper part of the wound, and placing the stump in such a position that the pus flowed freely out into a vessel placed to receive it. The period of suppuration was undoubtedly diminished by this free exposure of the wound to the air, and the application of balsam of Peru, a favorite remedy with Dr. Wood. The open method was, therefore, a decided improvement upon the old method of closing wounds, but it came far short of the present method, which prevents suppuration altogether, or reduces it to a minimum. Except for the unfavorable conditions incident to the injury, amputations are now among the most successful operations at Bellevue. Death by suppuration and its results, does not occur.

Excision of the larger joints was formerly a most doubtful and dangerous operation. The wounds were flooded with pus for months; and if the patient survived, it was only after the most desperate struggle. The specimens of exsected joints in the Wood Museum, honey-combed with channels through which pus flowed out from the deeper parts of the wound, will be lasting witnesses to the destructive pathological processes which the surgeons of a former period could not avert, and which brought to an untimely issue the best-planned operations. In dressing exsection wounds the older surgeons made ample preparation for suppuration. The wound was left open, and the limb was placed in such position as would allow the pus to escape most freely. For months the patient lay in the same position, waiting under the excessive drain, and often having as a dreaded complication extensive bed-sores. Now the surgeon completes the operation by firmly and accurately closing the wound at all points, except where the draining-tube

emerges. This tube is used only for the temporary purposes of relieving the wound of accumulating serous fluid, and is soon removed. As a rule, excision wounds now do not suppurate; union takes place by rapid and healthy granulation,

During the past year or two we have had under observation many cases of excision of the knee-joint, the hip-joint, the elbow-joint, and the ankle-joint, which have been repaired with suppuration. In one instance of old and destructive inflammation of the ankle-joint the articular ends of the tibia and fibula, the surfaces of the astragalus and os calcis, and all of the surrounding tissues had to be thoroughly scraped to remove the dead bone and fungous granulations. When the cavity was prepared for dressing it was enormous. But as all diseased structures seemed to be removed, and the wound appeared everywhere clean, it was dressed for union without suppuration. The wound did heal without other suppuration than a slight amount of pus, which discharged from a small carious surface. The health of the patient began at once to improve, and in due time she was about the ward, on crutches. We may now say of excisions as of amputations, that they are regarded as simple and very safe operations.

The ligation of large arteries was formerly justly estimated as a very serious operation. The common silk ligature, prepared by unwashed hands, was left depending from the wound. To do its work properly it must in due time sever the strangulated artery by the ulcerative process, and then be removed by traction. With the keenest and often most painful anxiety, the surgeon daily watched the wound to note the amount of suppuration, and gently tested the firmness of the ligature. If after the separation of the ligature the suppuration diminished, and finally ceased, the surgeon was happy and boastful of his success. But far too often the suppuration did not diminish, and to the dismay of the surgeon a slight oozing or gush of blood indicated to his practiced eye a fatal issue by secondary hemorrhage.

How desperately yet vainly he struggled against fate, by resorting to pressure, position, styptics, etc., the older surgeon can alone realize. The repeated hemorrhages, or uncontrollable outburst, at length placed the case in the category of unsuccessful operations. Now, how completely are all the conditions of the operation changed! It is no longer necessary to divide the artery by the ligature to accomplish our object, and thus endanger life by hemorrhage; but, on the contrary, we seek, while we interrupt the circulation sufficiently to effect our purpose, to strengthen the artery by our operation. The indications now are the opposite of those which before obtained. The ligature now selected is non-irritating, and preferably absorbable, as catgut. When applied, it may, or may not, divide the internal coats of the artery. In either

case the wound is completely closed and no suppuration occurs. In the repair the artery enlarges externally at the seat of the operation by nutritive action, while the coagula organize internally and close its calibre. Secondary hemorrhage after the ligation of arteries has, therefore, become an incident of the past. The conditions no longer exist which make it possible. Ligation of the common carotid is a familiar operation at Bellevue, and was often performed with great skill by Dr. Wood, who published an elaborate monograph on that subject. I aided him in the examination and collection of cases, and in the preparation of the text, and was impressed with the destructive effects of the ulcerative process which attends the separation of the ligature. Some time since I had occasion to ligate this artery, and applied the catgut ligature, cutting both ends close to the knot, and closing the wound perfectly. Union promptly followed, and nothing further was seen of the ligature. The patient died at the end of two months of cancer of the mouth and pharynx, and the autopsy revealed an enlargement of the artery at the seat of the ligature to twice its normal size, by a ring of new tissue completely encircling it. On incising the artery at this point, the remains of the ligature were found in this ring, and the coagula had organized and closed its cavity permanently. It was evident that the ligature had greatly strengthened the artery instead of destroying it, as in the old operation.

It follows that, if the major operations are now performed with so much success, the minor operations are correspondingly successful. If we take as an example the treatment of cold abscesses, the improvement is very noticeable. Formerly a cold abscess unconnected with bone, as in the thigh or on the back, were preferably allowed to open themselves. If the surgeon ventured to operate, he usually made a "valvular incision," and allowed part of the contents to flow out, and then closed the wound. This operation was repeated many times. When aspiration was introduced, it was regarded as a great advance. The fear of the surgeon was that air would enter the abscess cavity, and set up active suppuration. I recall a case of large abscess of the back, in a young woman, which, after consultation and much deliberation, Dr. Van Buren ventured to puncture directly. The interest taken in this bold operation was very great, and the progress of the case was watched with much anxiety by the operator. Profuse suppuration followed, and the patient nearly lost her life. Now these abscesses are promptly cured and without suppuration, by opening them freely, and with the curette, scraping out all the old granulations and diseased tissues; then thoroughly cleansing the cavity with bichloride solutions, and finally pressing the walls gently together with disinfected sponges and bandages, or other antiseptic



dressings. The walls of these abscesses, sometimes of enormous size, and many square feet of surface, promptly unite, and often under the first dressings.

And not less important is the change in the treatment of abscesses connected with carious bone. Abscesses in the lumbar and femoral regions, caused by caries of the spine, were once greatly feared at Bellevue.

Billroth's advice was very rigidly followed, viz: "If the abscess comes from a bone on which an operation is impossible or undesirable, do not meddle with it, but be thankful for every day it remains closed, and wait quietly until it opens, for thus there will be relatively the least danger." Now these abscesses are immediately opened and kept thoroughly cleansed, together with their sinuses, by bichloride solutions, with a marked diminution, and in some cases, a complete suppression of suppuration. In several instances of both lumbar and femoral abscess from spinal caries incisions have been freely made, the pus evacuated, and by means of the soft rubber catheter gently passed along the sinus, the carious abscess itself has been thoroughly and repeatedly cleansed and disinfected with carbolic or bichloride solutions, followed by rapid diminution and final complete cessation of suppuration. Meantime, the patients have rapidly recovered from the symptoms of blood-poisoning from which they have been suffering.

At a recent period a method of treating large abscesses and diffused collections of pus in cellular tissue by the introduction of large perforated drainage-tubes, was practised. Through these tubes the antiseptic solutions were frequently injected, with a view to irrigate the diseased surfaces and tissues. It was a most unscientific method, and was soon abandoned. Instead of it, we have the present rational practice of carefully opening all collections of pus, cleansing the cavities, removing all granulations and other diseased tissues, and closing the wound permanently. The former method often resulted most disastrously; the present never fails of complete success when properly performed.

Perhaps the most marked illustration of the great improvement in operative surgery in Bellevue, may be found in the unvarying success which attends the treatment of simple fracture of the patella by wiring together the fragments. It was eminently fitting that this operation, so novel and startling as to be received with almost universal ridicule by older surgeons, should have first been proposed by the great apostle of antiseptic surgery. By proposing and successfully executing this operation, he expressed his faith in his teachings in form more emphatic and convincing than language could. This procedure does, indeed, embody the very spirit and genius of the surgery of to-day, viz.: Boldness to audacity in the conception of an operation, and

conservatism the most absolute in the method and means employed in executing it. And yet this operation is now accepted as legitimate in Bellevue, and is of almost weekly occurrence in one or the other of its surgical divisions. And no operation, so inherently dangerous when performed according to old methods, has ever proved more successful. It has now been performed in more than a score of cases without an unfavorable result.

Though this paper was to be limited to a review of the comparative results of the ordinary surgical practices of Bellevue, formerly and now, with a brief commentary upon the means and methods employed, I cannot pass unnoticed the success which attends the practice of gynecology in that hospital. The surgery of the pelvic organs of the female is based on the same principles as those which govern the general practice of surgery in Bellevue. And the results are equally remarkable.

Septicæmia and pyæmia are almost unknown in the pavilion devoted to this branch of surgery, and recovery after operations is rapid and complete, unless the case is complicated with conditions quite beyond control. The following statistics show the great success of operations in this branch of practice at Bellevue. Dr. Wylie states that since November, 1883, he has performed laparotomy thirty times, chiefly in the Marquand and Sturgis pavilions, with five deaths. Of the cases proving fatal, two were hysterectomies, one for cancer of the uterus, and the other for a myoma weighing fifty pounds; two were cases of pelvic abscess, complicated with purulent collections in the fallopian tubes. All of the cases of ovarian cysts recovered.

In reviewing the surgical practice of Bellevue, it is not difficult to determine the essential feature of the present methods as compared with those of the past. Cleanliness is the one great object sought to be attained in all operations. Whatever may be the final conclusion of scientific students as to the cause of putrefaction in wounds, practically it is determined that the surgeon may, with the most absolute certainty, protect an ordinary open wound from suppuration. To effect this object he finds that he has simply to resort to those measures which are known to secure perfect cleanliness of the wound. The agents now relied upon and found efficient are: 1. Soap and water to external parts. 2. Carbolic solutions for the instruments. 3. Bichloride solutions to all surfaces and tissues. 4. Iodoform for external dressings. We may summarize the conditions regarded as essential to success as follows, viz.: *A clean operator; clean assistants; a clean patient; clean instruments; clean dressings.*—*Med. Record.*

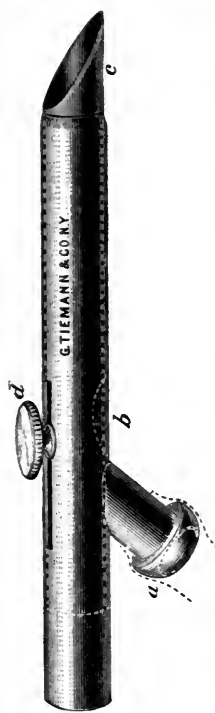
OXIDE OF ZINC, according to Prof. Peterson, of Kiel, is just as good as iodoform in the treatment of wounds, is not poisonous, is cheaper, and does not smell offensively.



## A NEW OVARIOTOMY TROCAR.

BY E. S. DUNSTAR, M.D., ANN ARBOR, MICH.

With a view of obtaining a less complicated as well as a less expensive ovarian trocar and canula, than the well-known and excellent instruments of Sir Spencer Wells and the "Fitch dome," I suggested to Mr. Stohlmann (senior partner of the house of George Tiemann & Co.), to make for me the instrument illustrated in the accompanying wood-cut engraving. The drawing (which is of half size) shows so clearly what the instrument is, that no elaborate description of it is necessary. It



consists simply of two concentric and accurately adjusted tubes, one sliding within the other, thus making a canula and trocar proper. The canula (*c*) is adjusted by the set-screw (*d*), and has in it a fenestrum shown in dotted lines at *b*. When the cutting point of the canula is withdrawn into the trocar, this fenestrum comes directly opposite the outlet tube (*a*), to which rubber tubing, at convenience, is to be attached. The instrument, in using, is held in one hand just like a pistol; the proximal end of it, which is capped with a solid convex plate, is placed in the hollow of the hand; the middle ring, and little fingers grasp it in front of the outlet (*a*), while the thumb and index-finger are free to fix or move the canula forward or backward as required by means of the set-screw (*d*). When the cut-

ting point (*c*) is withdrawn into the trocar, there is no sharp edge or point which can damage the tissues into which it may be introduced.

The special advantages claimed for the instrument are: 1, it can be held and used with one hand alone, leaving the other hand free for the operator to use as may be required, while the grasp (pistol-fashion) is so firm that the instrument is under perfect control; 2, the construction is so simple that the instrument can be cleaned and kept clean with ease; in these days of antiseptic surgery this feature in an instrument is an important consideration. By removing the inner from the outer tube every portion of both inner and outer surfaces of the instrument can be easily reached with a carbolyzed cotton swab, and there are no sharp angles, corners, or crevices in which septic matter can lurk to do its deadly work by being

carried into the tissues in operating; 3, it is, or ought to be, furnished at much less expense than either the Spencer Wells or the "Fitch dome."

The instrument is nickel-plated and burnished inside and out. I have used it in several ovariectomies, and it works with perfect satisfaction. I would suggest that if made of various smaller sizes and lengths it will be found an excellent and handy substitute for the trocars in use in general surgery.

## TREATMENT OF PELVIC HÆMATOCELE.

[This affection is so comparatively rarely met with that we are apt to become rusty in the treatment, hence it seems well to reproduce the following remarks of Dr. Alfred Wiltshire's from the *Lancet*.]

As to the treatment of pelvic hæmatoceles, the cardinal injunction in most cases is absolute rest and opium. The value of opium is here transcendent. It tranquilizes, relieves pain and enables the exhausted and collapsed patient better to bear the blood loss, while it compels repose, both mental and bodily. But to procure these desirable ends it must be given in full doses, and be repeated as may be necessary. The best method is to give it in one grain-doses of the solid opium, either in pill or powder. Next to solid opium, Battey's sedative solution of opium is good; but morphia is much less useful in these hemorrhages, especially in the cataclysmic forms. Ice and brandy, champagne, or other suitable stimulants may be requisite; and, above all, Valentine's meat-juice is most valuable. Peptonized meats and other foods (Bengers's, Darby's and others) may be useful adjuncts. In certain cases the hypodermic injection of ergotine of Tanret (Paris) may be helpful, and tincture of hamamelis may help in certain forms. The bladder should be relieved by catheterism with antiseptic precautions, as may be required. The use of astringents, such as gallic and other acids, is not great in these accidents, nor can I recommend the use of heavy bags of ice to the abdomen. But besides medical treatment, certain grave surgical questions arise in some cases, and demand urgent solution; for example, in cases where there are reasonable grounds for suspecting the source of internal hemorrhage to be a ruptured tubal or other pregnancy, and in similar accidents, such as bursting of a vein in the pampiniform plexus or elsewhere, where the diagnosis is sufficiently clear; in short in those cataclysmic intra-peritoneal bleedings where rapid dissolution is threatened, prompt operation may not only be justified, but become imperative to rescue the patient from impending death. It must not be forgotten, however, that even in ruptured ectopic gestations many patients recover without operation, as has happened several times within my own experience.

The difficulty of accurate diagnosis is no doubt sometimes great, but not always; and when the well-balanced judgment arrives at reasonable grounds for belief that hemorrhage threatening to be rapidly fatal is going on unchecked from a controllable vascular lesion, then a bold, but not rash, interference is justifiable, and in these days of heroic abdominal surgery, laparotomy should be done without delay.

During the later stages of pelvic hæmatocoeles watchful supervision of the patient is necessary. The bladder should be carefully attended to with scrupulous cleanliness and great gentleness. Bed-sores should be prevented if possible. The bowels as a rule should seldom be opened. The mouth often becomes sore from the glazy and raw condition of the tongue and lips, therefore all food should be bland. Sedative mouth washes give much relief (borax, myrrh, wine of opium, mucilages, and orange flower or rose water). The better patients are fed and cared for, the sooner does the effusion disappear according to my experience. Care should be taken to guard against relapses or exacerbations, which are apt to occur about the time of the next catamenial period. I have been able occasionally to predict a fresh effusion at these epochs; and when such happens, it is followed by fresh manifestations of hæmatic jaundice. There is periodicity about these forms of hemorrhage, and the explanation of effusions occurring at the inter-menstrual or fortnightly periods is that it is part of a minor nîsus that happens then. The condition of the vascular system will warn the physician, and the sphygmograph or finger may indicate increased arterial tension, while the eye can see the venous turgescence. Undue vascular excitement may be reduced by aconite, amyl-nitrite, nitro-glycerine, the bromides, etc. The pelvic viscera may be quieted by *actæa racemosa*, monobromide of camphor, Indian hemp, conium, gelsemine, and so on, given internally, and by vaginal pessaries of iodoform, conia, morphia, atropia, etc., or by rectal suppositories. An atmosphere of turpentine about the sick chamber is good, both for styptic and purifying influences. With reference to the puncture of hæmatocoeles, I should as a rule, deprecate opening, and would counsel caution in resorting to any operative measures. Should relief become necessary in the latter stages from suspicion of suppuration or decomposition of blood, or from clear evidence of intolerable or dangerous tension, then aspirate by the vagina and not by the rectum; but operation is generally undesirable, and should be carefully resorted to. During convalescence hot air and water will be found beneficial, and where absorption is tardy, poultices of scalded sea-sand and brine baths are essential.—*Med. and Surg. Reporter.*

#### ABSORPTION OF INTRA-PERITONEAL LIGATURES.—

Dr. J. C. Irish, of Lowell, Mass. (*Boston Medical Journal*.) says:—Since the intra-peritoneal treatment of ovarian pedicles with short ligatures has so universally replaced the older modes by clamp or ligatures brought out at the lower angle of the wound, it has become a question of great interest to learn what becomes of these foreign bodies enclosed in the abdominal cavity. This subject has been extensively investigated by Spiegelberg and Waldeyer, with a series of experiments upon animals. Doran, also, reports ten cases in which he has examined the pedicle at some time after an ovariectomy.

These observers found that a plastic effusion extending from the proximal side of the pedicle to the distal, over the ligature, would establish a vascular connection with the ligature portion, sufficient to prevent its necrosis. Afterwards, young granulation cells would spring up and insinuate themselves among the individual fibres of the ligatures, separating the threads and unravelling them, and finally, that these fibres would become entirely absorbed.

In exceptional instances, however, the ligatures would slip off the stump, become encysted, and remain without further change.

I have been unable to learn the length of time required for the completion of this process of absorption, or the variations in extent of time that occurred in different cases. The following case, however, demonstrates that complete absorption of the ligatures may take place, as it seems to me, in a very short space of time.

January 13, 1885, I removed an ovarian tumor from a patient at Lowell. The pedicle was ligated in two sections with "Tait's Knot." The ligatures were cut short and enclosed in the abdominal cavity. The patient made a rapid and complete recovery from the ovariectomy. But May 5th, that is four months less eight days after the date of the ovarian operation, she died of acute pulmonary tuberculosis. At the post-mortem examination, a very careful search was made for the ligatures. All trace of them had disappeared from the pedicle. Although it was very improbable, from the manner in which the pedicle had been tied, that they could have slipped off and become encysted, still so thorough an examination of the pelvic cavity was made as to convince us that it was impossible that they had found any place of lodgement there. Therefore, in this instance, the entire absorption of the ligatures had taken place in twelve weeks or less.

EXTERNAL TREATMENT OF NIGHT-SWEATS.—The *Therapeutic Gazette* (August 15,) remarks concerning the treatment of night-sweats by external applications, that Nicolai (*Gazette Médicale de Paris*, June 6, 1885) obtained very good results in the case of night-sweats of phthisical patients, and

others, by the employment of eight grammes of chloral dissolved in two tumblersful of a mixture of equal parts of brandy and water. Every evening before going to sleep, the patients are washed off with a sponge soaked with this solution, and if that does not serve to control the sweating, the shirt in which the patient sleeps is soaked with the same solution and then dried. The effect of this treatment is claimed to be especially satisfactory in cases of children, not suffering from phthisis, in whom night-sweats are present. Sometimes four rubbings with this solution are sufficient to entirely arrest the night-sweats for several weeks.

The tincture of belladonna is also highly recommended by Radakow for the suppression of the night-sweats of phthisis by external friction with a mixture of four grammes of the tincture of belladonna with thirty grammes of water, the friction to be made about two hours before the ordinary onset of the sweating. The fluid is to be poured into the palm of the hand and then rubbed over the entire body, with the exception of the head and the extremities, and the manipulation may be continued until the skin becomes quite moist. This treatment has been employed by Radakow in fifty cases, and he claims that it has not failed in a single instance, although sometimes localized sweatings appeared on the parts which had not been bathed with the tincture of belladonna.—*Boston Med. & Surg. Journal*.

**JAUNDICE AND PAIN IN BILIARY COLIC.**—Mr. Lawson Tait, in the *Lancet*, July, 1885, offers some suggestions as to the reason why, during the passage of gall-stones, there is frequently no jaundice. In fifteen cases of cholecystotomy there has been no history of jaundice, and Mr. Tait has found that the occurrence of jaundice, either in the skin or in the urine, during and after the passage of the gall-stone, is of extreme rarity, and not, as has been believed common. Mr. Tait believes that the explanation of this fact lies in the following anatomical conditions of the cystic and common ducts. The common duct is not so long (3 inches) as most text-books assert, and is much less rigid and more easily dilatable than the cystic duct, which is larger than is usually described, namely, one inch. Hence, we can understand how a stone, if not of very great size, will cause intolerable agony while passing through the unyielding cystic duct, and without a trace of jaundice ensuing, the gall-bladder alone being its propellent force; but the moment it enters the common duct the extending impulse will be increased by the influence of the whole excreting force of the liver, so that its passage through the common duct is more rapid. The chief symptom then, that of pain, is due to the slow passage of the calculus through the unyielding cystic duct, whilst its rapid passage through the easily distended and much larger common duct

gives no time, in the majority of instances, for the production of jaundice, which only takes place after long-continued obstruction of this the common duct.—*Brit. Med. Journal*.

**VACCINATION AFTER EXPOSURE.**—According to the last quarterly report of the proceedings of the Illinois State Board of Health, 144 persons suffered from small-pox, the disease having been contracted at a negro "protracted meeting," and of this number 120 had never been vaccinated. Within from three days "to about a week," 14 of these 120 persons were vaccinated. Amongst the remaining 106 cases 38 died, being a mortality at the rate of 35.84 per cent. Of the 14 vaccinated after exposure all recovered; and amongst the 37 who had been vaccinated prior to exposure, one single person, vaccinated once twenty-five years before, died. The late Mr. Marson attached no value to vaccination if performed after an interval of four complete days from the exposure, his statement being as follows: "Suppose an unvaccinated person to inhale the germ of variola on Monday; if he be vaccinated as late as the following Wednesday the vaccination will be in time to prevent small-pox being developed; if it be put off until Thursday the small-pox will appear, but it will be modified; if the vaccination be delayed until Friday it will be of no use—it will not have had time to reach the stage of areola, the index of safety, before the illness of small-pox begins." But the Illinois report gives prominence to the belief that vaccination has a positive therapeutic value as well as the prophylactic power to which Mr. Marson referred, and in the fifth annual report of the Board of Health it is alleged that "if a patient be vaccinated during the febrile stage and the vaccination progress normally . . . the areolar stage of vaccination will be reached before the dangerous tenth day of the variolous disease, and, as has been repeatedly witnessed, the graver disease will be aborted, jugulated, or materially modified." Hence it is inferred that it is never too late to vaccinate; we prefer, however, the alternate maxim laid down, which is that in cases where there has been possible exposure "it is never too soon to vaccinate."—*London Lancet*, Aug. 22d.

**CALOMEL IN BOWEL COMPLAINTS.**—The older practitioners were great advocates of the mercuric salts—particularly of calomel—in bowel complaints; and some of our recent therapeutists of the "physiological school" adhere to the old practice only with a modified dosage. The old explanation of the *modus operandi* of mercury in these complaints was that it induced a flow of bile, and the bile in turn arrested putrefactive changes in the contents of the alimentary canal. It would appear from recent experiments by Sternberg (*Med. News*, Sept. 12), that calomel does correct decom-

position in the alvine contents, not necessarily, however, if at all, by stimulation of the hepatic secretion, but by its direct destructive action upon the bacteria of putrefaction. Sternberg says:—

“The following simple experiment may, perhaps, serve to explain the demonstrated value of calomel as an “alterative” in bowel complaints attended with offensive discharges: If a little calomel is broken up in a test-tube with putrid beef-tee, a black precipitate is thrown down. I have made no attempt to examine this black precipitate chemically, but it can scarcely be anything else than the black oxide of mercury which my recent experiments show has decided antiseptic power when present in putrescible material in the proportion of 1:1000, and entirely prevents the putrefactive decomposition of beef peptone solution in 1:500.”

**SALISBURY STEAK**—The Salisbury steak is made by taking the best slices of the “round” of the beef, and chopping it with *dull* knives. The object is not to cut, but rather pound the meat. By thus treating it, the pulp comes to the top, and the tough, fibrous portion remains below. This pulp is scraped off and made into cakes, like sausage-cakes, or in the shape like a good-sized steak and *gently* broiled on a gridiron. It has been found that meat gently cooked is more digestible than raw. The fire must be good, so that the meat may be rapidly broiled—that is, be cooked on the outside and almost raw inside.

A little salt and pepper and a small amount of butter added make a not at all unpalatable dish, and one which contains *all* the strength of the beef, with the tough, indigestible portion entirely separated. This diet is used exclusively in chronic cases, by physicians professing to treat according to the Salisbury method. They use but few drugs, and what they use are mainly tonics. The diet is used not only in diseased digestion, but diseases of liver, kidneys, stomach, bowels, nerves, etc., and remarkable results are said to have been obtained.

*N. Y. Medical Times.*

**CHRONIC ATONY OF BLADDER.**—P. Donovan, F.R.C.S.I., Kingstown, writes: In answer to the inquiry of “Old Member,” as to the treatment of chronic atony of the bladder, I would recommend him to pass an electric current each day for a period of five minutes, from a Stohrer’s battery, from the sacrum to the pubis, and along the perineum, and to try the following mixture at the same time, with the cold sitz bath, or, better still, sea bathing every morning: R Tinct. ferri perchloridi, ʒ ii.; liquor strychnie. P.B., ʒ ss; liquor ergotæ, P.B., ʒ ii.; syrupi limonis, ʒ i.; aquam ad ʒ viii. One ounce to be taken twice daily.

I have lately had a gentleman under my care, who had lost all power over his bladder, and had

to be relieved two or three times each day by the catheter. He is now perfectly well, with full power over the organ, although he is seventy-eight years of age. The above treatment in this case was most successful.—*Brit. Med. Jour.*, Aug. 22d.

**EDINBURGH MIXTURE FOR GOUT.**—The solution of the biniodide of mercury in potassic iodide, known as the Edinburgh mixture, is of great service in the treatment of gout. Dr. C. R. Illingworth (*Brit. Med. Journ.*, May 30, 1885) prescribes it as follows:

R	Sol. hydrarg. bichlorid. (P.B.)	ʒ vj
	Potass iodidi	ʒ ss
	Inf. quassia	ad. ʒ vj

M.—Sig. Teaspoonful every three hours.

If there be much pain, he adds two-minim doses of the solution of morphine, or five-grain doses of chloral and bromide of potassium with simple syrup. Of course when congestion or actual inflammation of the kidney or other internal organs exists, this preparation should not be used.—*Therap. Gazette.*

**THE CAREFUL PATIENT.**—The following joke is at the expense of a Chicago doctor. He was about to anesthetize a patient, when, in answer to a question, he informed the victim that he would be entirely unconscious and know nothing until the offending growth had been removed. The patient accordingly commenced to fish his loose change out of his pocket. “Oh, you need not mind the fee until I am through,” remarked the considerate doctor. “I don’t intend to pay you yet,” returned the patient, “I wish merely to count my money, to see how much I have.” The doctor saw the point and was much amused.

**SUBCUTANEOUS LIGATURE OF THE BRACHIAL ARTERY.**—Dr. Raimondo Cannizzaro, being called upon to ligate the brachial on account of a wound involving the radial and ulnar branches, made a valvular opening by drawing the skin tight, tied the artery with carbolized silk and allowed the skin to slip back covering the wound. The superficial wound healed by first intention, and in seven days the patient left the hospital cured.—*Revue de Chirurgie*, August 10, 1885.

**THE USE OF IODINE IN DIPHTHERIA.**—Adamson (Practitioner) adds his testimony to the efficiency of the iodine treatment. He lost only two patients out of 55 treated with the tincture alone, although some of the cases were very grave. For adults he gives from five to seven minims every hour, and for children between six and 12 years of age from two to three minims every two hours. Special mention is made of syrup of quince for disguising the taste of the drug.—*N. Y. Med. Journal.*

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John, N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAHLER, 23 Rue Richer, Paris.

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*The LANCET has the largest circulation of any  
Medical Journal in Canada.*

## THE PHYSICAL IMPROVEMENT OF MANKIND.

The physical improvement of mankind is no new problem. From a remote period it has received more or less attention; but not until our own time has it received that attention which its importance demands. Gradually this problem, in one form and another, has been forcing itself upon the attention of thoughtful minds, until now it has come to the front as a question of the first magnitude. To this end all civilized governments make money appropriations, and in various ways promote sanitary work. All this is highly gratifying; no better evidence could be afforded of the spread of knowledge. The common schools of a country are the most powerful agents employed in sanitary reform. Filth, no less than superstition, is the patrimony of the ignorant. Witness the opposition of the ignorant masses of Spain, Italy, and our own country, to necessary sanitary measures, in the present terrible visitations. Wholesome sanitary conditions are not only evidences of advanced civilization, but are part and parcel of civilization itself.

The physical improvement of the race through improved surroundings, presents an attractive field to the philanthropist. In none are good results more fruitful or more self-satisfying. It implies less disease, less suffering, and saving of time and the expenses incident to sickness; it means more power for the wage-earner, more food and clothing,

and more home cheer and comfort. Such are a few of the blessings that unfailingly come to mankind through the adoption and practice of well-known sanitary laws. Sickness, suffering, and premature death are seen on every hand in all lands, even in the most favorable to health and longevity. Especially is this true of the young, of whom one-fourth die before it can be said they have commenced to live, and hence, so far as human eye can see, were born to no purpose, leaving the pain, sorrow, labor and expense incident to their birth, life, and death, wholly uncompensated. Of the number who survive the earlier years of infancy, a large per centage die before reaching maturity; another large per centage are cut off in the earlier years of manhood and womanhood. Early death is the rule, and ripe old age the exception. The remedy for all these ills, the sanitarians tell us, lies in improved modes of living—cleaner surroundings, abundance of food, better clothing, and more comfortable dwellings.

Good and commendable as all this is, it does not meet the whole case. In the present day, thousands are living surrounded by sanitary conditions as favorable as can reasonably be looked for. They are well fed, well clothed, and well housed; but are they free from sickness? do they rear their young, and die of old age? All these blessings they have in a fuller degree; but they, too, are sick, lose their children, and die before old age overtakes them. True, the cottage of the poor is, *par excellence*, the home of infantile disease, contagious diseases, consumption, and kindred affections; but the palaces of the rich are by no means exempt. Possessed of all that money can do for them, even they have been unable to solve the problem—how to live out their allotted three score and ten years, to say nothing of the additional years of promise through extra vigor of constitution. Hence we see that outward conditions, however beneficial, are of themselves inadequate to raise the standards of health and longevity to the degree intended by an overruling Providence. It could never have been intended that half the race should perish before reaching years of usefulness, and that but a few of the other half should die of ripe old age. Clearly enough there are elements of destruction other than hunger and dirt at work, and it behooves us to search them out, in order to be able to shun them, and induce others so to do.

In point of fact, these destructive elements are already known, though but little heeded. This neglect arises partly from the delicacy of the subject, and partly from the difficulties in the way of applying a remedy. We should not, however, be deterred from doing our duty by such considerations. Effects are often avoided by a proper knowledge of causes, even where compulsory laws would be inoperative. That the sins of the fathers are visited upon the children, is a truth no less certain in a physical than in a moral sense. "Like begets like" is a truism as applicable to the human family as it is to the herds of the stock-raiser. Robust parents produce, almost infallibly; healthy, vigorous children. We do not look for such results from parents of diseased or enfeebled constitutions. The remedy is obvious. The stock-breeder would say, Weed out all the weaklings, and prevent the mating of all but the perfect in form and development. That would be a sure and scientific remedy, one readily enough applied to dumb brutes, but largely impracticable as regards mankind. That would be a practical working out of Darwin's theory of the survival of the fittest; but man, as a moral, free agent, and king of all the earth, would refuse to come under laws and regulations so much calculated to thwart his passions and inclinations, however much in the interests of the race such laws might be.

How much could be accomplished by restrictive laws is a question for the political economist. Probably such a law would be found oppressive and inoperative. Man's two-fold nature is a barrier to the application of laws restricting his liberty in this behalf. Besides the undesirable unions based on mutual attachment and affinity, many more are the result of social and material considerations. Evidently the springs of action are too numerous, and motive power too strong, ever to be regulated or controlled by statutory laws. Amongst savages such laws are unnecessary; Darwin's theory has full play. The hardships and exposures incident to their mode of life kill off the weak and sickly, so that only the healthy and strong survive. Hence transmitted disease is rarely met with amongst the uncivilized. It is in civilized life, where circumstances favor effeminacy, and where the life of the sickly offspring is preserved by intelligent care and the skill of the physician, that the blighting, painful, and destructive influences

of transmitted debility and disease are mostly seen and felt. Strange indeed, and most unfortunate too, that the very conditions which we most covet, and to which we point with most pride, should be freighted with danger to health and life. Paradoxical as this may seem, it is, nevertheless, true. Here extremes meet: In the lower strata, hunger, dirt, and exposure, productive of suffering, disease, and death; and abundance, cleanliness, and comfort, productive of effeminacy and transmitted debility, in the upper strata. A noteworthy illustration of this fact was recently given to the public by the St. Louis Medical Society, some of whose members have a world-wide reputation. That learned body actually had the temerity to discuss, openly and frankly, woman's enjoyment of the sexual function. The consensus of opinion arrived at was, that desire and pleasure were the rare exception; pleasure without desire, more frequent; neither desire nor pleasure, common; while loathing and pain were far from uncommon. Here we have a certain proof of lack of vitality and physical development, as productive of evil as it is contrary to nature. It was ordained that woman should bring forth her young in pain, but to ask her also to conceive in pain is the acme of cruelty. Mothers so constituted cannot be expected to produce a healthy, vigorous offspring. Consider also the conjugal unhappiness resulting from such unnatural physiological conditions. The women of St. Louis are probably a fair type of womanhood in general, on this continent at least; and, if so, civilized life must undergo a reformation before it can be said to favor a high degree of physical development. It is important that medical men should know and consider these matters. Perhaps they cannot do a great deal to mitigate the evils to which we have called attention, but it is to them alone suffering woman can look, and society at large, for counsel and guidance in these difficult and delicate matters. We all can do a little, if we only would, and drop a hint here and a word there, as we pass in and out amongst the people. In this quiet way each can impart information which is certain to bear good and abundant fruit. The medical profession is open to criticism for neglecting to supply popular works treating of these and kindred topics. No kind of information is more eagerly sought after, and none more difficult to obtain. What literature the people have, of this



kind, has been disseminated by quacks, and written with an eye to business more than the imparting of useful knowledge. What is wanted is more light, which is, after all, the surest remedy for all errors, be they physical or moral.

### BRITISH MEDICAL ASSOCIATION.

The fifty-third annual meeting of the British Medical Association was held at Cardiff, Wales, July 28th to 31st, under the presidency of Dr. Edwards, of Cardiff. The proceedings were opened by a short address from the retiring President, Dr. Cuming, of Belfast. The report of the Council of the Association was the next order of business. The report recommended the purchase of a site and the erection of a building for the use of the Association, at an estimated cost of \$75,000 for the site and \$50,000 for the building. This occasioned considerable discussion, but was finally carried, and the Council was authorized to buy or lease a site, and erect a building for printing and publishing the *Journal*, etc.

The President then delivered the annual address, in which he gave a description of Cardiff, its mineral resources and other natural advantages, its sanitary work, etc. He said that the health officer of to-day stands, as did the Hebrew priest of old, between the living and the dead. He next referred to the British Medical Association, which had now come to be a power in the land, socially, politically, and morally. He also alluded to the advances in medical science which had been made during its growth, as, for example, the use of chloroform, ether, iodoform, the bromides, antiseptics, the study of disease-germs, etc.

The address on medicine was delivered by Dr. Samuel Wilks, of London. He claimed that diseases arise from peculiarities of climate, food, race, and surroundings, influenced by heredity. Bacteria and bacilli in pathology were now in the ascendancy, but he believed the fashion would, in a measure, pass away, as Liebig's theory about zymotic ferments had done. He ridiculed the idea that each microbe had its specific pabulum. Disease was often the result of irregularities in development of organs, and want of harmony in the functions of various organs; in illustration of which he referred to the curious intermittent or remittent action of many organs. Dr. Wm.

Roberts delivered the address on therapeutics, in which he fully considered the important subject of dietetics, treating first of milk, to which he gave the first place among liquid foods. Next to milk he ranked beef-tea and other meat decoctions and infusions. Beaten-up eggs also received a due share of attention, as being a highly nutritive form of liquid food. He also alluded to the enormous trade which has grown up of late years in "prepared foods," and stated his preference for the several articles of food in their simple state, with which a skilful nurse could prepare what was necessary for the patient if provided with proper cooking utensils and materials for preparing peptonized articles of food.

The address on surgery was delivered by Dr. E. H. Bennett, of Dublin, on "Injuries of the Skeleton," and the best method of studying fractures. This, he claimed, was accomplished, not by dissecting cadavers or experimenting on animals, but by studying many cases of the same kind. He had studied one hundred cases of Colles' fracture, and found no less than forty-eight cases of impaction. According to this statement, we must be prepared to meet these two conditions in nearly equal numbers. In Pott's fracture, he found a number of specimens in which the fibula was broken in the upper third instead of the lower. Where the symptoms resemble a sprain of the ankle, the fracture of the fibula may be overlooked. He cited a number of fractures in different parts of the body in support of his views regarding the study of fractures.

In the section on obstetrics, the address was delivered by Dr. Henry Gervis, London, upon the subject of "Death-rates from childbirth and cancer, and the value of antisepsis in midwifery." The decline in the general death-rate was first touched upon, and then the decline in death from childbirth, which he expected would continue. He warmly advocated the early and judicious use of the forceps, great care in the prevention of hemorrhage, and the use of antiseptics both before and after labor. He advised careful examination of the parts after labor, and the stitching up of lacerations. Corrosive sublimate or boracic acid solutions he considered preferable to carbolic acid. He hoped much good would arise out of the series of seven questions proposed by the collective investigation committee on the subject of puerperal



fever. In regard to cancer of the uterus, he approved of early operative interference whenever practicable, and had hopes that much good would be accomplished. While admitting the influence of heredity, he believed in the local origin of cancer.

The papers in the sections were of great interest, and the discussions very profitable. The social side of the meeting was also well sustained.

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### NEW METHOD OF TESTING WATER.

As is well known, all methods of testing the sanitary qualities of water have hitherto been very imperfect. The chemist has been able to determine the presence of mineral substances and gases, and to trace the existence of organic impurities; but the biological condition of the water was unknown to him, and he was, therefore, unable to say whether it was fit for sanitary purposes, or not. Through the labors of Koch, a new method has been introduced, which is called the biological test. This method has been satisfactorily tested by Dr. Percy Frankland, of London, England, (*LANCET*, Sept. 26) in his recent study of filtering and precipitating agents, and has met with great favor. A complete account of the process, by Prof. Warden, of the Calcutta Medical College, has been published in the *Chemical News*, and reprinted in pamphlet form. The test consists essentially in mixing a known volume of water with "sterilized liquid meat peptone gelatin," counting, after a definite period, the colonies of micro-organisms which develop, observing the extent to which they liquefy the gelatin, and, if necessary, cultivating them in various ways. The utmost possible care is, of course, necessary in these operations, and special apparatus is required. The paper gives full directions and illustrative drawings; and the importance of the system is well illustrated by Prof. Warden, when he reminds us that a drop of a cholera stool added to a liter of pure sterilized water, could not be detected by chemical analysis, whereas the bacteriological examination would "with absolute certainty demonstrate the presence of a comma-shaped micro organism, while subsequent cultivation would indicate whether the organism was the cholera bacillus or not."

The scientific and practical value of this new method cannot be over-estimated. The testing of the sanitary purity of water will become a matter

of certainty, instead of a hap-hazard approximation of the truth, as was formerly the case. It will open up a new and interesting field for the expert micro biologist, as it can only be undertaken by one who has had experience in the study of bacteriology.

**STRYCHNIA IN DIPHTHERITIC PARALYSIS.**—In the *Deutsche Medische Wochenschrift* for May, Dr. Reinhard, of Bautzen, relates the case of a boy aged three years, who after an attack of diphtheria, suffered from symptoms of paralysis in the muscles of the palate and various parts of the body, his gait being uncertain and staggering. Tonic treatment, including iron, was of no avail, and twelve days later the symptoms had advanced so far that death seemed imminent from paralysis of the respiratory muscles. Internal remedies were useless, as the power of swallowing was lost; recourse was therefore had to the subcutaneous injection of sulphate of strychnia, 1 milligramme (0.015 grain) daily. The next day the breathing was quieter and the muscles were less flaccid, and only fifteen doses were required to establish convalescence on a firm basis. No unpleasant symptoms were set up by the strychnia. Dr. Reinhard mentions this case, not as anything new, but as bringing an old remedy to the remembrance of his fellow-practitioners.

**BATHS FOR RHEUMATISM.**—Turkish baths are now largely prescribed in New York for those forms of rheumatism resulting in deformity of the joints. The baths are ordered twice a week. Several ladies who have passed through the alkaline treatment, find that these baths afford them great relief. The medicine which seems to give the most satisfaction is liquor ammonia, in twenty-drop doses, three times a day, in a half tumbler of cold water. The bicarbonates of potassa and soda are objectionable, because they are liable to produce a skin disease resembling herpes.

**A NEW THERMOMETER.**—A new fever thermometer has been invented by Immisch Bros., of London, Eng. It has the appearance of a lady's small silver watch, with one hand moving over the dial, which is graduated according to Fahrenheit's scale. Owing to its small size it may readily be placed in the axilla, and takes but  $3\frac{1}{2}$  minutes to reach its maximum temperature. It is absolutely

water-tight, and is therefore not affected by dampness. There is also no danger of breaking, even should it fall upon the floor.

**KOUMISS IN CONSUMPTION.**—In an article in the *Medical Bulletin* on the use of Koumiss in the treatment of consumption, Dr. Clifford Dock says that after two months' trial in one of his patients the results were most gratifying. The nausea which had been troublesome was entirely removed, and all ordinary articles of food were taken with impunity. The dyspnoea was greatly relieved except on vigorous exertion. The affected lung was greatly improved, and the general health bid fair to carry the patient many years into the future. This remedy can be obtained from W. S. Robinson, Druggist, 732 Yonge Street, or R. R. Martin, 171 Yonge Street, Toronto. Samples sent on application.

**PARALDEHYDE AS A HYPNOTIC.**—This new remedy bids fair to supplant chloral hydrate as a hypnotic in certain cases.

The drug may be administered as follows :

R.—Paraldehydis..... 5 j  
Pul. Tragacanth, Co..... grs. xx  
Syr. Aurantii.....  
Spts. Chloroformis.... m xv  
Aqua..... ad 5 iij—M

Sig.—The whole to be taken at one dose at bedtime.

**ANTIDOTE BAG.**—Dr. Murrell advises that every physician should keep an antidote bag, which should contain every drug and instrument needed in ordinary cases of poisoning. It should always be kept filled and ready for use ; so that, in case of emergency, the doctor could take it along or send for it, and not be compelled to look for stray bottles or instruments at a time when a life may depend upon a minute.

**ENUCLEATION OF DISEASED GLOBES.**—Dr. Noyes, of New York, in a discussion on a paper read by Jonathan Hutchinson at the meeting of the Ophthalmological Society, London, Eng., said that after twenty-five years' experience with enucleation he had come to the conclusion that indiscriminate removal of diseased eyes for the purpose of preventing sympathetic ophthalmia was a doubtful practice. Of late years he had not so largely advised

enucleation, and in so doing he believes he has saved many eyes. We agree with Dr. Noyes, and hold that an inoffensive globe should not be removed simply because it useless.

**TREATMENT OF GONORRHOEA.**—Gonorrhœa may be successfully treated with the following injection :

R Zinci sulph. . . . . grs. xxv ;  
Bismuth subnit. . . . . 3 iss ;  
Ext. belladonnæ, . . . . grs. xx ;  
Aqua, . . . . 3 viii.

M.—Sig. Inject one or two teaspoonfuls four or five times a day, and just before retiring.

We have found this more generally useful than any other injection we have ever employed.

**MODERN SURGERY.**—We desire to call attention to an article in another column, from the pen of Dr. Stephen Smith, of New York (*Med. Record*), on the comparative results of operations in Bellevue Hospital. The article is worthy of a careful and attentive perusal, indicating as it does the line of advance in modern surgery in one of the leading hospitals in America.

**REMOVAL.**—Dr. J. M. Cochrane, who has held the position of Medical Superintendent of the Hamilton Hospital, has removed to this city to commence practice. He carries with him the best wishes of the Hospital trustees and many friends in Hamilton, and we heartily welcome him to our midst.

**CORONER.**—Robert Mark, M.D., of Ottawa, has been appointed Coroner for the County of Carleton ; Chas. P. Pitcher, M.D., of Jerseyville, Ont., for the County of Wentworth ; W. H. Hamilton, M.D., of Port Arthur, for the District of Thunder Bay ; and J. M. Hutchinson, of Brussels, for the County of Huron.

**APPOINTMENTS.**—Dr. R. M. Fairchild, of Brantford, has been appointed Assistant Physician to the London Asylum ; Dr. T. W. Reynolds, of Hamilton, Assistant Physician to the Hamilton Asylum ; and Dr. J. Simpson, of Bowmanville, to a similar position in the Rockwood Asylum, Kingston.

In speaking of premature menopause, Dr. T. Gaillard Thomas said : " When called upon to express an opinion in the early part of a supposed

pregnancy, you should always say that up to the end of the third month no one can decide the matter by even the most careful examination."

The death of Dr. J. L. Atlee, of Lancaster, Pa., brother of W. L. Atlee, M.D., of Philadelphia, is announced in our American exchanges.

### Books and Pamphlets.

POISONS, THEIR EFFECTS AND DETECTION, by Alexander Wynter Blyth, M.R.C.S., F.C.S., etc. 2 volumes. W. Wood & Co.

"And if a man did need a poison now," surely these two volumes might supply him with a very comprehensive catalogue of all sorts, from both the organic and the inorganic world, and in this age of wondrous discoveries, murderous inventions and lightning speed, it behooves every person to press to the front, and possess himself of the very latest intelligence from the great battle-field of science, and get hold of good books before they pass, as their predecessors have done, into the dark vale of the forgotten. Uncle Toby said that nothing was made to last forever. It must be a paragon of a good book on any branch of medical knowledge, that will not die out in ten years, otherwise how could the infinitude of new ones find either buyers or readers, to say nothing of shelf room or dimmed eyesight. Still we hope that this work of Wynter Blyth will have sufficient vitality to elongate its existence over a dozen winters, and when it ceases to present the blythe aspect of youth, we would trust that its author will continue able to write with vigor, and to bring it into harmony with the requirements of advancing science, of which he has certainly been an assiduous cultivator. The paper and typography of these volumes are both very creditable, and well entitle the publishers to the grateful respect of the profession.

THE BLOT UPON THE BRAIN: Studies in History and Psychology. By Wm. W. Ireland, M.D., Edin., formerly of H.M. Indian Army, Corresponding Member of the Psychiatric Society of St. Petersburg, and of the New York Medico-Legal Society; member of the Medico-Psychological Association. Edinburgh: Bell & Bradfute. Toronto: Williamson & Co.

This excellent work, by Dr. Ireland, of Preston-

pans, Scotland, will be read with delight not only by psychologists, but also by those not directly interested in the subject. Technical terms have been avoided as far as a clear understanding of the subjects under discussion would allow. A careful study of diseased brain function has enabled the author to give explanations of some important events in history. The work deals with the hallucinations of Mohammed, Luther, Swedenborg, and Joan of Arc; the insanity of power, as exemplified in the Claudian-Julian family, Marcus Aurelius, etc.; the hereditary neurosis of the family of Spain; unconscious cerebration; the relation of words to thought; dual functions of the double brain; and many other equally important subjects. The book is written in a popular style, and yet deals with abstruse subjects of absorbing interest. Many of the papers have already appeared in the *Journal of Mental Science* and in *Brain*. The author acknowledges advice and assistance from Dr. Clouston, of Edinburgh, Dr. Grieson, Prof. Turner, and others, in the preparation of the work.

"'Tis the blot upon the brain  
That will show itself without."

TENNYSON.

A COMPLETE PRONOUNCING MEDICAL DICTIONARY, embracing the terminology of medicine and kindred sciences, with their signification, etymology, and pronunciation; with an Appendix, comprising the Latin terms and phrases occurring in medical works, etc. By Joseph Thomas, M.D., LL.D. Philadelphia: J. B. Lippincott & Co. Toronto: Williamson & Co.

Thomas' Dictionary really fills a long felt want, viz, that of a thoroughly reliable pronouncing vocabulary of the terms used in medicine and kindred sciences. The etymology of the various terms used in medicine has received special attention, the importance of which can scarcely be over-estimated. Another special feature of the work is the giving of a literal translation of the various Latin phrases occurring in the Dictionary. The work has been prepared with great care, thoroughness and accuracy, and cannot fail to be appreciated by all intelligent readers. We bespeak for the work the most favorable consideration at the hands of the profession, and unreservedly give it our highest commendation. It is printed on good paper, in clear type, and bound both in cloth and sheep. Price \$5; in sheep, \$6.

**THE PRINCIPLES AND PRACTICE OF SURGERY**, by John Ashhurst, jr., M.D., Prof. of Clinical Surgery in the University of Pennsylvania, etc. Fourth edition enlarged and revised, with 597 illustrations. Philadelphia: Lea Bros. & Co., 1885. Toronto: Williamson & Co.

The above work furnishes in a concise manner a condensed but comprehensive description of the treatment of surgical affections and the principles upon which it is based. No pains have been spared in the present revision of this most excellent work to render it worthy of the continued favor and support of the profession. The general arrangement of the volume is the same as in previous editions, but there has been a slight increase of new material which has necessitated the addition of upwards of fifty pages. The series of illustrations have been improved by the introduction of a large number of original wood-cuts. The work is, upon the whole, a faithful and complete representation of the advanced condition of modern surgery, and is especially to be commended to the attention of students and general practitioners.

**THE SCIENCE AND ART OF MIDWIFERY**, by W. T. Lusk, A.M., M.D., Prof. of Obstetrics and Diseases of Women and Children, in the Bellevue Hospital Medical College, etc. New edition revised and enlarged, with numerous illustrations. New York: D. Appleton & Co., 1885. Toronto: Hart & Co.

The new edition of this excellent work is just to hand, and is cordially welcomed. We do no injustice to any other author when we say that Lusk's Midwifery is surpassed by no other work of the kind in the English language. Great care has been exercised in its revision, and the work is fully abreast of the most advanced views on this important subject. We commend the work to the attention of our readers.

**INSOMNIA AND OTHER DISORDERS OF SLEEP**, by Henry M. Lyman, A.M., M.D. Chicago: Keener & Co. Toronto: Williamson & Co.

The above is a well printed minor octavo, on good paper, containing 237 pages. The author has probably had in view general popular instruction, rather than that of the medical profession. He has therefore very appropriately treated his subject in a manner sufficiently plain and untechnical to render the work acceptable and useful to the laity. The chapters on dreams, clairvoyance,

somnambulism and hypnotism, are very interesting, and by the lovers of the marvellous some parts of them will be read with unusual interest.

**BURR'S MEDICAL INDEX**, adapted to the use of Physicians, for the annotation of particular references to matters found in Text-books, Medical Journals, &c. The Burr Index Co., Hartford, Conn.

This will be found a most useful auxiliary to the library of every physician by enabling him to make notes for future reference in the course of his reading. It is conveniently arranged with thumb holes cut in the edges of the leaves, arranged with a projecting alphabet printed in gold letters on Morocco leather. It is scientifically and specially arranged for the needs of the physician and surgeon. All words entered are indexed by the first two letters. We heartily commend the work.

**FOWNE'S MANUAL OF CHEMISTRY**, Theoretical and Practical. A new American, from the twelfth English edition, embodying Watts' "Physical and Inorganic Chemistry." With one hundred and sixty-eight illustrations. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

Fowne's Chemistry is too well known to require any special notice at our hands. It has been for years the standard work on chemistry in all our medical schools and colleges. The present edition has been prepared with great care and is worthy of continued favor. We welcome it to our library, and commend it to the attention of our readers.

**RENAL AND URINARY AFFECTIONS**, by W. Howship Dickinson, M.D., Cantab, F.R.C.P.

This is the August issue of the enterprising house of W. Wood & Co. It is both comprehensive and minute, and it cannot fail to be highly appreciated by every member of the profession, who desires to be well instructed on the numerous morbid conditions of the whole urinary system. The illustrative plates are presented in a better style of art than heretofore.

**INDEX CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, U. S. ARMY**. Vol. vi. Heastie—Insfeldt. Washington, 1885.

Great credit is due Dr. Billings in carrying out so satisfactorily this great enterprise. It is without parallel in the history of catalogues. There

are already six immense volumes, and yet the letter I is only reached in the category.

**ELEMENTS OF MODERN MEDICINE.** For the Use of Students and Practitioners of Medicine; by R. F. Stone, M.D., Prof. of Materia Medica and Clinical Medicine, College of Physicians and Surgeons, Indianapolis, Ind. New York: D. Appleton & Co.

This is an abridged work in pocket-book form, presenting the more advanced views of leading authorities, with reference to general pathology and therapeutics. Under general pathology are included articles on the origin, nature, and duration of disease, chief symptoms, diagnosis, prognosis, and treatment. In the second part will be found what is regarded by the author as an improved classification of drugs, followed by articles on their physiological action, indications, and methods of use. The work contains a fund of useful information culled from the best authorities in the old and new world.

**A HANDBOOK OF OPHTHALMIC SCIENCE AND PRACTICE,** by H. E. Juler, F.R.C.S., of St. Mary's Hospital, London, etc., with one hundred and twenty-five illustrations. Philadelphia: Lea Bros. & Co. Toronto: Hart & Co.

This work has been favorably received both at home and abroad. Some valuable additions have been made by Dr. Charles A. Oliver, of Philadelphia; for example: the description of a new astigmatic disk, and its use; the effectiveness of different mydriatics, etc. The test-types of both Jaeger and Snellen will be found at the end of the volume. The work will be found a reliable and useful guide in this branch of medical science.

**THE YEAR-BOOK OF TREATMENT FOR 1884.** A Critical Review for Practitioners of Medicine and Surgery, by various contributors. Philadelphia: Lea Bros. & Co. Toronto: Hart & Co.

In the preparation of this work the medical literature of all countries has been placed under contribution, and care has been taken to include such recent pathological and clinical work as bears directly upon treatment. It contains not only a complete account of all the more important advances in the treatment of disease, but also a critical review of the same by competent authorities.

**A TREATISE ON PRACTICAL CHEMISTRY AND QUALITATIVE INORGANIC ANALYSIS, FOR THE USE OF LABORATORIES AND SCHOOLS,** by F. Clowes, D. Sc., Lond., Prof. Chemistry, University College, Nottingham. Third American, from the fourth

English edition. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

The work before us is divided into seven sections.

1. The preparation and use of apparatus. 2. Preparation and properties of gases and liquids. 3 and 4. Analytical operations and reactions. 5. Analysis of simple substances. 6. Full analytical course and tables. 7. Laboratory fittings, apparatus, chemicals and reagents. It will be found a systematic, intelligible, and fully-equipped laboratory guide for students in practical chemistry.

**AIDS TO THE ANALYSIS OF FOOD AND DRUGS,** by H. Aubrey Husband, M.B.C.M. F.R.C.S., Eng., author of "Students Handbook of Forensic Medicine and Medical Police," etc., etc. London: Balliere, Tindall & Cox. New York: Putman & Sons.

The object of the work is to place in the hands of medical practitioners, medical health officers, and medical students, short, concise, and reliable processes for the detection of the commoner adulterations in foods and drugs. A list of the apparatus required is given, also the preparations of the standard solutions used and the method of testing their accuracy. The work will be found very convenient and serviceable.

**APPLIED MEDICAL CHEMISTRY; a Manual for Students and Practitioners of Medicine,** by Lawrence Wolff, M.D., Demonstrator of Chemistry, Jefferson Medical College. Philadelphia: P. Blakiston, Son & Co. Toronto: Willing & Co.

The arrangement of the volume has been made in accordance with the author's system of demonstration. 1. Apparatus and Manipulations; 2. Chemistry of Poisons; 3. Physiological Chemistry; 4. Excretions and Concretions; 5. Sanitary Chemistry. The latest forms and processes, as well as their modifications, have been given wherever advisable.

**THE PEDIGREE OF DISEASE;** being six Lectures on Temperaments, Idiosyncrasy, and Diathesis, delivered in the Royal College of Surgeons, Eng., by Jonathan Hutchinson, F.R.S. New York: Wm. Wood & Co.

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### Births, Marriages and Deaths.

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On the 20th ult., Calvin McQuesten, M.D., of Hamilton, Ont., in the 85th year of his age.

# THE CANADA LANCET.

A MONTHLY JOURNAL OF

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CRITICISM AND NEWS.

VOL. XVIII. TORONTO, DEC., 1885. No. 4.

## Original Communications.

### THE EPIDEMIC ZYMOTIC DISEASES OF ANIMALS AND HOW THEY ARE COMMUNICATED TO MAN.\*

BY J. A. GRANT, M.D., F.R.C.P., LONDON.

President Medico-Chirurgical Society, Ottawa; Consulting  
Physician General Hospital, and County Carleton  
Protestant Hospital.

GENTLEMEN, With your kind permission, I will digress from the usual path in delivering an annual address on the progress of medical science, and confine the few observations I have now to offer to "The Epidemic Zymotic Diseases of Animals, and How they are Communicated to Man." For many years, while directing some little attention to Natural History, I have noted points in pathological anatomy closely allied with the diseased manifestations in the "genus homo," and being a wide field for the practical exercise of pathological research, I felt confident such would not be uninteresting to the members of our Society. The subject is one of vast importance to our common country, inasmuch as it involves millions, in our live stock, irrespective of its scientific aspect. Endemic and epidemic diseases are not alone confined to the human species, but extend alike to animals, and the manifestations are doubtless of peculiar interest. The analogy is so close, that they are designated by the same names. Several are propagated in the human organism, and many present pathological information of great importance. The late Dr. Farr, of England, specified these as diseases which distinguish one country from another, and whose occurrence form epochs in chronology. The exact cause of these diseases, although not positively known, is supposed in the

animal organisms to act like a ferment, hence the term "Zymotic." According to the most recent enquiries the generation of "organic germs," originate in the individual, or by fermentation in the diseased excretions of the organism, and thus transmitted through various media from body to body, at sensible and insensible distances.

It is a well recognized fact that the death rate, in almost every country, from such sources of disease, is very considerable. The result of literally packing animals together, which can doubtless be scarcely avoided, as in the trains of our various railroads, cannot escape the attention of the most ordinary observer. The atmospheric signal is perfect in its way. Thus infection rapidly spreads, where diseased germs exist, and the consequences are frequently most serious. According to Prof. Law, since 1842, England has lost over 450 millions of dollars through the contagion of cattle imported from the Continent. The stamping out process by slaughtering all the diseased cattle, and thorough disinfection afterwards, and the exclusion of all diseased animals from the country, has been productive of the best results. Diseased germs are doubtless the very foundation of the diseases of animals, and the early recognition of incipient development is of vast importance. Diseases in animals are divided into two classes; the *Exotic* or *uncommon*, and the *indigenous* or *common*. Of the first class, we have *small pox in sheep and birds*, Pleuropneumonia of cattle, Rinderpest, Malignant diseases of the generative organs of the horse kind, Malignant cholera of animals, Aphous fever, known as foot and mouth disease. Of the second class, or indigenous diseases, belong Glanders, Rabies, Contagious foot rot, Tuberculosis, Malignant asthma, Hog cholera, or intestinal fever of swine, Influenza, Strangles, Canine distemper, and Horse pox, seen in the cow, goat, and pig. In each of these diseases there is a zymotic influence at work, precisely as in the development of disease in our own species. Hippocrates, in his time, enunciated clearly the influence of impurity in air, soil or water, as factors in the development of disease zymotic in character. The impurity of soil has much to do with the production of disease, in both milk and meat, thus influencing the human family and spreading the germs of disease of a most serious character. The death rate in man and animal, from foul stock yards, and filthy alleys in towns

\* Annual Address read before the Medico-Chirurgical Society, Ottawa.

and cities, is much greater than the public are aware of. Disease may remain endemic, or spread by animal transportation, hence the vast importance of street cleanliness and quarantine measures, so as, if possible, to *stamp out* individual cases. The chief epidemic which has occasionally influenced Canadian cattle trade is pleuro-pneumonia, and the rapidity with which such has been checked, through isolation and disinfection, is creditable to the agricultural departments in the Local and General Governments. Until recently there has been greater attention bestowed upon the arrest of disease in animals than man, as far as Governments were concerned. Happily now, however, matters are undergoing a change, and sanitary legislation is attracting a greater degree of attention from the powers that be.

"The Contagious Pneumonia of Cattle" has been noted several times in Canada, although not to any great extent. It has on several occasions been introduced into the United States, by the importation of foreign stock. In order to avoid any such dissemination of disease, a most careful system of quarantine is now adopted by the Canadian authorities. The period of latency of the poison of pleuropneumonia in the system, is from two to six weeks, at which time it is developed with all the well-defined symptoms of pneumonia. The death rate averages between 50 and 60 percent. In this disease the poison is exceedingly subtle, virulent and most readily communicated. I have more than once noted epidemic pneumonia in the inhabitants of this district, most rapid in character, and arrested with considerable difficulty. Treatment in either case can only be undertaken with thorough seclusion and disinfection. The early recognition of this disease is important, in order that animals thus affected should not be slaughtered for sale.

Rinderpest, or Russian Cattle Plague, is a most contagious disease amongst animals of the same species. Its chief characteristic is the manner in which the mucous membranes assume a congested state, involving also the lining membrane of the stomach and bowels, associated with a high temperature and extensive desquamation of both skin and mucous membrane. So far, little indeed is known of this disease in Canada, the protection against which is strict quarantine and destruction of the infected animals

Foot and mouth disease, or *Apthous Fever*, is a species of contagious eruptive disease, confined chiefly to cloven-footed animals, and has been known to extend to man. This disease is usually ushered in by a rise in temperature and a general feeling of discomfort, and within a day or two, is followed by large blisters on the mucous membrane of the mouth, tongue, fauces, udders, and the parts in and about the clefts of the hoofs. It has been known to follow armies, and is said to be exceedingly communicable. The contagious disease is spread much more by contact than by the atmosphere. Milk from such diseased animals is often carried to individuals, the infant most frequently coming in for its share of the diseased influence. Soreness and otherwise unaccountable lameness in cattle, is a most significant indication, when associated with an apthous state of either the tongue or fauces. Thorough disinfection is here also necessary, and ablution with carbolic acid lotion, with isolation for 10 or 15 days after the disappearance of the disease.

A case is recently recorded in a German veterinary journal, where a veterinary surgeon contracted foot and mouth disease from a pocket-handkerchief he had used while examining beasts suffering from this disease. The next day he was seized with a violent headache and pains in his limbs, high fever and a feeling of irritation in the hands and feet. On the third day the fever subsided, and there appeared an eruption of an apthous character on the tongue, lips, mouth, and edge of the nose. After eight days the various symptoms subsided without any serious consequences.

Epizoo, or epizooty, otherwise known as influenza or horse epidemic, has prevailed to a considerable extent on both sides of the Atlantic, extending at the same time to both man and beast. In 1881 quite a severe epidemic of that character was experienced in various parts of Canada, and many fine animals fell victims to the subsequent pneumonic action which frequently followed. Such epidemics are not of frequent occurrence. The exact cause, although attributed to atmospheric, electrical and other agencies, is still a matter of considerable doubt. So far the two freest portions of Canada from this disease, and chiefly owing to their sequestered character, are Prince Edward Island and Vancouver Island. Absolute quarantine, across large bodies of water,



is said to be one of the best means of preventing the spread of this disease.

*Intestinal Fever of Swine*, misnamed *Hog Cholera*, is a disease which, to a moderate extent, has visited this neighborhood during the present season, and several fine animals have fallen victims to its influence. According to Prof. Law, "this disease is attended by congestion, exudation, blood extravasations in the mucous membrane of the stomach and bowels, by general heat, and redness of the surface, and by the appearance on the skin of spots and patches of a scarlet, purple or black color. The animals had not been dead over ten or twelve hours when the whole mucous and muscular coats of the large intestines became black, and easily lacerated from incipient mortification." The chief cause of this disease, is supposed to be *swill stuff* of breweries and distilleries fed to these animals, crowded together in a confined space, and an exceedingly impure atmosphere. It is said to be infectious, and spreads rapidly from animal to animal. Much good could be accomplished by the most thorough investigation of this disease.

Pork, in its various forms, as an article of diet, is in very general use, thus the diseases of the hog play an important part in relation to public health. Parasites, although not zymotic in character, infest the flesh of this animal, are exceedingly important, inasmuch as they frequently produce very serious disturbances of the system. The parasites are the *Trichina Spiralis*, the *Cysticercus Cellulosæ*, and the *Echinococcus*. Very few cases of *Trichinosis* have, so far, been noted in the Dominion, and up to the present, they only number sixteen. We are more fortunate than in Germany, where epidemics from this cause are of frequent occurrence, chiefly owing to some forms of sausages largely used by the masses in a partially cooked condition. *Trichinae*, as a rule, are killed by perfect cooking, the safest plan by far, when this form of meat is used. Measly pork contains the immature form of one of the *tapeworms of man*, which originates in the parasite known as the *Cysticercus Cellulosæ*. This condition of pork is frequently seen in our markets, but it is not as serious in its consequences as *trichina*. The two most frequent forms of tapeworm in Canada, are the *Tania Solium* and *Tania Saginata*—the former from measly pork, and the latter from measly veal or beef. Tapeworm from beef

is generally the result of partial cooking, just as in the case of pork. Raw material in either instance favors the life of the parasite, and hence the subsequent trouble.

The appearance of *Echinococcus* disease in man is, according to present records, exceedingly rare in Canada, as up to the present time only 8 or 10 cases are known. The liver with these cysts is unfit for food; not, however, the flesh, from which they may be removed when not numerous, and the carcass be still fit for use as food.

Glanders, or *Farcy*, requires more than a passing notice from its importance, and the fact of its fatality when communicated to man from the horse, marking its *contagious febrile character*. Its chief specific peculiarities are inflammatory lesions of the *nasal* and *respiratory* mucous membranes, lymphatic vessels and glands, marked constitutional depression, and frequently accompanied with a pustular cutaneous eruption. Glanders and *Farcy* are really one and the same disease, the affection of the respiratory mucous membrane is followed by implication of the lymphatics. Glanders in man is very rare. Last July a case was recorded in the Montreal general hospital, under Dr. Geo. Ross, which was well defined, and terminated fatally. So far we have no positive case originating in man, and it is always communicated by direct inoculation of virus from the diseased animal. It is somewhat common with horses, and is known to spread rapidly, and, by some, it is maintained that it possesses "a volatile infecting principle," the period of incubation varying from three to eight days, and sometimes even to three weeks. The longer the incubation, the less acute the disease, as a rule. Its symptoms, as a whole, frequently simulate acute rheumatism. Some cases have ended fatally in one week, but, in the usual acute form, the average duration is about sixteen days, but, occasionally it will be protracted for several weeks, and even months, under which circumstances the prospect of recovery is favorable. The wound through which the poison is admitted becomes inflamed, tense, painful, and usually has an erysipelatous circumference. The ulcer enlarges, presents a chancre-like aspect, discharging sanious, offensive matter, and the lymphatic vessels around present a knotted, cord-like, irregularly, nodulated condition, known in man as the *farcy buds*. According to Virchow, resolution and absorption occasionally take place,

but more frequently deep seated abscesses form, and constitutional symptoms, indicating a low type. Within the first or second day of this disease (and sometimes longer) scattered collections of red spots appear on the skin, small, and resembling flea bites, subsequently they become papular, and elevated above the skin like small shot, and assume a yellow color. They are considered as due to the deposit of some neoplastic material, which gradually softens and becomes disintegrated. They subsequently become vesicular, or sero-purulent with inflamed bases. Otherwise, various modifications of character have been noted, of minor importance. The mucous membranes, particularly that of the nose, become affected, and, in fact, subject to specific inflammation and ulceration. Both in man and horse, the disease is supposed to originate by the application of the virus to the nose mucous membrane. The disease is liable to extend to the bronchial and pulmonary tissues generally. Rheumatism, typhoid fever, pyæmia, syphilis, and tuberculosis have all been mistaken for glanders. Thorough disinfection— isolation— destruction of stalls and harness, are all necessary to arrest the disease. So far, recorded cases point out that recoveries from this malady are rare, particularly in the acute form. The preeminently debilitating character of this disease indicates a stimulating, soothing, and supporting treatment. Inhalation of iodine and carbolic acid are strongly recommended, and thorough syringing of the nose with (Condy's fluid, (solution) carbolic acid lotion, or iodised water, all of which have been found productive of beneficial results.

Dr. Kitt, of Berlin, has recently examined the material taken from a "farcy bud" after the hair had been carefully shaved off, and the skin thoroughly washed with mercuric chloride. The contents of the bud brought in contact with blood serum, and on the 3rd or 4th day, isolated yellow points appeared, which soon increased in size, that on examination and most careful experiment, proved to be true glanders bacilli. These bacilli are somewhat smaller than those of tuberculosis, but are a little thicker and color easily in methyl-violet. Rabbits, inoculated with pure cultivations of these bacilli, produced, beyond a doubt, nasal and pulmonary glanders, demonstrated by subsequent microscopical examination.

There are various other forms of diseases which attack man and beast much in the same manner,

such as cerebro-spinal meningitis, known as blind staggers, anthrax, and tuberculosis. As time, however, will not admit of particulars on these various subjects, I shall now offer a few notes on tuberculosis, as this disease is one attracting very great interest. Dr. Bell, the able editor of the *Sanitarian* (N. Y.) 1877, August, published an article on "Tuberculosis in milch cows, and the Contagiousness of Tuberculosis by the Digestive Organs." He states, that according to various experiments performed in Germany and other parts, tuberculosis may be induced in various domestic animals by feeding them with tubercular matter, with flesh of tuberculous animals, and even with the milk of tuberculous cows, and he concludes by the very cogent question: may not the like effects result from the use of such food in the human species? Through the kindness of an offal contractor in Brooklyn, he made various post mortem examinations of cows, and in several instances demonstrated beyond a doubt, the existence of tuberculosis of the lungs in these animals. He states that the milk of cows affected with that disease is likely to induce tuberculosis in the child, and usually commencing as intestinal catarrh.

The recent observations of Mr. Heard, M. R. C. V. S., of New Port, demonstrate that the bacillus tuberculosis of man is the same as the bacillus tuberculosis of bovines. The cultivated tuberculosis of man, when introduced into cattle by inoculation, results in tuberculosis.

Milk from tuberculous animals does not contain the bacillus tuberculosis, and cannot produce the disease unless the udder itself is the seat of tuberculosis, which is frequently the case. There are many recorded cases which prove that tuberculosis is a very infectious disease, transmissible from man to man and from animals to man. Fully one-seventh of the human family death rate, is from tuberculosis, hence the vast importance of the most careful enquiry as to all circumstances connected with the development of this disease.

Typhoid fever is well known to be promoted by impure milk, as in the epidemic pointed out by Dr. Ballard, of Islington. The subject is one deserving of every consideration, and in the hands of the physician, much good may be accomplished by actively directed endeavors, and much practical benefit will doubtless spring from the wide-spread thoughtfulness now to be observed in various parts

of the Dominion, as to the necessity and value of hygienic measures. According to Dr. Bowditch, there are more than "two hundred thousand human beings slaughtered annually in the United States by preventable diseases. May we not ask what is the death rate from such in Canada? The climate of Canada is certainly conducive to health, still there is ample room for the exercise of sanitary measures in order to stamp out such epidemics as greatly increase the death rate, and bring ruin to once flourishing commercial interests.

As to diseases in animals, the members of our profession hold great power in their own hands. We have observed how disease may spread from the lower species to the human family, and engender trouble and suffering, much of which, through careful observation and moderate direction, might be obviated. The English and French schools of the past, as well as the present, have worked nobly with a benevolent and philanthropic object in view, giving such light to science and the world as the people of our age enjoy. What illustrious names have we in John Hunter, Jenner, Bichat, Corvisart, Audral, Louis, Pasteur, Koch, and Sanderson, whose labors in comparative pathology have formed the very basis of modern thought, in both physiology and morbid anatomy. Buckle says, that "between Bichat and Aristotle 'I know no middle man.'" As for Hunter, like the meteoric light, his intellectual power flashed as the product of his century, and he certainly possessed a rare genius which could not fail to impress the age in which he flourished.

From the various facts coming under our observation as to the spread of disease, does it not appear reasonable there should be some degree of inspection as to both milk and meat, by the proper sanitary authorities, in order to guard more thoroughly the public interest. In Germany such is most rigidly carried into operation, and no meat is offered for sale until first reported upon in the *abattoir* by the scientific pathologist, and thus a good work is accomplished.

In conclusion let me say, I hold it to be the duty of every member of the profession in our city to connect himself with our society, to attend its meetings as often as practicable, and to contribute each year a few facts, at least, to our transactions. Thus our profession affords ample scope for the exercise of individuality. No one man knows all

minds, and delicate shadings of disease, which may escape one individual, may be grasped by another, and thus we are enabled to reciprocate nature's power, and place on record the daily observations of life's duty. Practitioners in rural districts, contrasting their opportunities with the larger sphere of hospital city work, may erroneously conclude that no new discovery can possibly be made in such a line of thought and practice. A single fact, however humble, is a valuable contribution to science, and such may as well be observed in country as city. What a blessing it would be if some rural practitioner could possibly define the exact cause of diphtheritic epidemics of recent origin at Chelsea, Ironsides, and Montebello. Pure air, fresh water, and nourishing diet in abundance, and yet this dire disease and its marked fatality. The death rate in the Gatineau country within the past few years from this disease, has certainly been very great.

There are difficulties to contend against in our profession, not greater, however, than in the performance of any work, worthy of our very best efforts. Our number in this city is not great, and there is an earnestness of work of a most commendable character. A few still remain in a measure outside our medical gatherings, the loss being truly theirs. The sympathetic power which unites us, assists in the development of intellectual activity and vigor. Years are rapidly passing on, and the connecting link will sever. We have the pleasing gratification of knowing that our efforts have not been altogether unsuccessful. Genius will raise one man in a million above his fellows. But, after all, "genius is an infinite capacity for taking pains."

Whatever the advantages may be, whether at the rural fireside or the city hospital, there are rare opportunities of doing good. Let the work be carefully and conscientiously performed, with painstaking application, and, rely upon it, the reward will come. Thanking you in an especial manner for my reappointment to the presidency of the society for the coming year, let me invite your hearty co-operation in the noble work placed in our hands.

A retailer of methylated spirits, in Glasgow, has been fined 20*l.* for each offence, having sold half-a-gill of methylated spirits as a beverage, to two persons on the 9th of August last.

## WARBURG'S TINCTURE IN CANADIAN PRACTICE.\*

BY J. H. DUNCAN, M.D., ETC., THAMESVILLE, ONT.

MR. PRESIDENT,—In an address lately delivered by Dr. Henry Howard, of Montreal, the following words occur: "True physical science when applied to the treatment of disease, consists in recognizing the fact, that for a physical effect there must be a physical cause, and in our treatment of disease our duty is when we see effect to look for a cause; treating disease from any other standpoint, no matter how successful such treatment may be, is empiricism, it is not science; and until this truth is recognized and acted upon by the medical profession generally, none of us can claim to belong to a purely scientific profession." These words truly present to us as a profession a grand ideal, but alas, under existing circumstances, only an ideal. No man aware of the position of medicine to-day, will for one moment dare to claim that it now does, or soon can occupy the position of a truly scientific profession. We meet with morbid physical conditions on every side; for some, for many, nay, for most of these, we do not know the physical cause in its entirety. We cannot wait to know, men are suffering and calling to us for help. In many cases if we do not know the cause, we do know the therapeutic agent that will give relief, a knowledge drawn not from science but from professional accumulations of experience. It is our duty to use these means at hand, and through the mists of empiricism to watch and carefully follow the golden threads of science that seem to blend together the web of medical truth, leading, as they do, upward and onward to perfect knowledge, and systematised fact. In coming before you to-day advocating the use of Warburg's tincture, I confess to the advocacy of apparently a most unscientific remedy, an egregious piece of poly-pharmacy, a remedy at which science must stand aghast, or turn away in disgust, for the multitude of its ingredients renders a scientific knowledge of its *modus operandi* utterly out of the question.

Warburg's tincture was introduced to the notice of the profession about thirty-five years ago, as a new and most efficacious remedy in the treatment

of the more malignant types of malarial disease. It was then highly recommended by Dr. Babington as an antimalarial and general tonic. Among the surgeons of the Indian Army it was held in highest esteem, in so much that it was soon by many held to be an indispensable in operations, either civil or military, in any of the tropical malarious regions. Excepting where special conditions rendered it almost a necessity, the tincture has not been generally received or tried by the profession, and that cannot be wondered at, seeing its composition was for long a secret. Now, since its composition has been made known through Professor Maclean, of Netley, its unscientific poly-pharmacy makes the profession stand aloof with a superior scientific smile.

Warburg's tincture contains thirteen ingredients:—To each ounce we have quinine gr. ix. ss, three purgative ingredients, viz.: aloes, ten or eleven grains, rhubarb about five grains, and one grain of agaric of larch; we have then aromatics to the amount of twenty-five grains, myrrh, cubebs, zedoary, saffron, fennel, elecampane, angelica, and all wound up with that relic of barbaric medication, Confection of Democrates, which is composed of something like fifty gums and aromatics. It would be an easy matter to fill pages with quotations extolling the virtues of the tincture, it will be sufficient to make a short quotation from Professor Maclean, of Netley Hospital:—"It will be seen that quinine is the most important ingredient in the formula, each ounce bottle containing nine grains of the alkaloid; its presence has been detected by every chemist who has attempted its analysis, and never doubted by any medical man who has used the tincture: many will say, after all this vaunted remedy is only quinine concealed in a farrago of inert substances for the purposes of mystification. To this objection my answer is: I have treated remittent fevers of every degree of severity, contracted in the jungles of the Deccan and Mysore, at the base of mountain ranges in India, on the Coromandel coast, in the pestilential highlands of the northern division of Madras Presidency, on the malarial rivers of China, and in men brought to Netley Hospital from the Gold Coast, and I affirm that I have never seen quinine, when given alone, act in the manner characteristic of this tincture, and although I yield to no one in my high opinion of the inestimable value of qui-

\* Read before the Ontario Medical Association, in London, June, '85.

nine, I have never seen a single dose of it given alone to the amount of nine grains and a half suffice to arrest an exacerbation of remittent fever, much less prevent its recurrence; while nothing is more common than to see the same quantity of the alkaloid in Warburg's tincture bring about both results."

A few cases briefly cited will suffice to indicate the results I have obtained from its use, and the special lines of disease in which it seems to me to be a valuable addition to our therapeutic armamentarium. (1.) As regards malarial remittents, I cannot say much, for they are rare in Canada. One case I did treat with Warburg, with the most satisfactory results, but the patient said he would rather die than be cured by that medicine. (2.) Malarial intermittent fevers.

CASE I.—Mrs. R. L. —, an emaciated sallow woman, aged 26. Had been suffering from intermittent fever for over a year, never getting respite for more than a few days at a time; quinine had been used freely but with little effect, and certainly no lasting effect, as she had during this time been under the care of a regular physician. Other anti-malarials had doubtless been tried, but as to that I cannot speak positively. She was suffering from a severe paroxysm when I saw her. I ordered a sharp mercurial purge, and followed that by the administration of an ounce of Warburg; she sweat freely, but not excessively, and never had another paroxysm; her health under simple tonic treatment rapidly improved, and she has only once since had even threatenings of the chills; then, she applied for another bottle of the tincture, which effectually prevented the threatened recurrence.

CASE II.—The second case is one kindly furnished to me by the President of our Association. Early in August of 1883, I received a letter from Dr. Worthington, saying, that a case of severe intermittent fever had come to him from Cairo, Ill.: that it had resisted ordinary remedies, and asking, if practice in a malarious district had furnished me with any special means for treating these obstinate cases. I at once sent a bottle of Warburg, with directions. The Doctor's report is as follows: "I at first gave quinine in moderate doses, without effect; then in antipyretic doses, as high as twenty grains without the least effect, apparently. I procured some Warburg's tincture from you, and on the 18th I gave

him the tincture in accordance with your instructions, and on the 20th he was free from the paroxysms. The form of intermittent was quotidian. The tincture acted like a charm." In no case have I never used it in intermittent without temporary benefit, and in only two in which lasting results were not obtained. One of these was associated with a chronically enlarged liver; in this case Warburg only produced temporary benefit, and mountain sage was honored with success. The other was a case of phthisis, in which daily chills and fever were utterly uncontrollable by every means within my reach except Warburg, and that irritated the bowels so as to render it useless. At last I found that both chills and fever were absolutely and immediately controlled by  $\frac{1}{3}$  grain of morphia, hypodermically, during the cold stage, later than that it was useless to control fever.

In the treatment of intermittent neuralgia, I might mention many cases, but one will do as a specimen of the power of the tincture. Mrs. B. applied for treatment in April last: she said she had for a year past been suffering from an intense headache every day, lasting from sundown to after midnight. I used quinine in half drachm doses without any effect, but to produce ringing in the ears and nausea. Arsenic was freely used without any benefit. I attempted to reduce the pain by gelsemium without effect, croton chloral used for the same purpose was of little use. I then tried Warburg, the first bottle rendered her easy, and though slight pain still recurred, she pronounced herself well; another bottle completely removed the difficulty, and it has never returned.

In cases of septicæmia I have found it the most prompt and reliable remedy I have ever used, almost immediately reducing the temperature, removing headache and producing free sweating. I have seen the most satisfactory results when quinine seemed of little use in double the doses given of Warburg.

In spasmodic asthma, the results of the administration of full doses of Warburg gives generally prompt relief.

My object in bringing this subject before the Association, is not to furnish anything new or strange for thought or discussion, but simply to bring into more prominent view a preparation that is in Ontario little known, hence slightly tested, and consequently very indifferently appreciated. I

would therefore urge upon the profession in Ontario that Warburg should get a fair trial: (1.) In obstinate cases of remittent or intermittent malarial fevers. (2.) In intermittent neuralgia. (3.) In septic fevers from whatever cause, and (4.) In spasmodic asthma, especially when it assumes malarial regularity in the return of its paroxysms.

I would not desire to see Warburg's tincture substituted generally for quinine, for it is very unpleasant to take, and expensive, but it should be in every doctor's office or on the shelves of the drug store where he gets his medicine, and used either where ordinary methods fail to relieve, or when a prompt, powerful, and certain effect is wanted. Several objections are urged against the tincture.

(1.) It is said to produce exhausting perspiration. I may answer that this may be the case in tropical climates, but not here. I have used it in all classes of cases, but never observed anything more than moderately free diaphoresis.

(2.) That it is no better than quinine with stimulants and aromatics. This may be true, that is all the tincture is, quinine with stimulants and aromatics; but I contend, that we at present know of no combination of stimulants and aromatics that can equal Warburg in intensifying, and at the same time modifying the action of quinine; till we can find a superior combination, let us use Warburg. No one who has used it fairly, will fail to admit that it acts with much greater power and certainty than quinine alone.

It becomes an interesting question, why is quinine in Warburg's tincture more potent than quinine alone? The answer seems to me to lie here. In the tincture quinine is readily and quickly absorbed, and being powerfully stimulant, waking the malaria-dulled nervous forces to activity; they more promptly and readily react to the quinine, which, I think, may be regarded as simply the physiological antidote of the malarial poison. Be the cause what it may I trust Warburg may get a fair trial, and hold its place till a better preparation is brought forward.

#### OVARIAN TUMOR, OPERATION. RECOVERY.

BY J. E. BROUSE, M.D., BROCKVILLE, ONT.

Although in the active practice of the profession since 1861, my only experience of ovarian tumour,

and the operation for its removal, occurred on the 19th of February, 1881, when I was present at two ovariectomies by the celebrated specialist, Dr. Thomas, of New York. In each instance the tumour was colloid, and both the women died shortly after removal from the table. The gravity of the operation, and the improbability of an inexperienced surgeon, without the help of skilled assistants, and a specially trained nurse to take charge of the patient; being able to conduct so formidable an undertaking to a successful issue, so impressed me, that I determined, in the unlikely event of being consulted in such a case, never to attempt the operation but to send her to one more skilled than myself, and who had often performed it. But as the sequel will show, I was fortunately forced into doing what I had thought never to attempt.

In Jan., 1883, Mrs. H. brought her daughter, A. H., *æt.* 24, to my office. She said her daughter was unwell every two weeks, and was "bloated." She was of a dark complexion, very much emaciated, face drawn, and anxious worn look. Tailoress by trade, worked at it for the past nine years. Has done little machine work, as it always caused pain in her side. Menses appeared at fourteen; nearly always regular: once went two weeks over time; discharge lasts three to four days, pain severe one day before ceasing, with appearance of flow, which is less than normal. Health good until a year past; during winter and spring of 1882, she had at times, pain in left iliac region, obliging her to unfasten her skirts to ease it. May, 1882, she noticed that her abdomen was enlarging, and it increased so much as to cause her corsets to project, and she was compelled to tie the bottom part down. The growth gradually increased until September, her menses meantime appearing regularly; that month, however, she was unwell twice, and became so every two weeks until December, when menses ceased entirely. When she became unwell every two weeks, the pain, formerly preceeding each monthly period, left her. In December she had to enlarge her dresses. Complaints of loss of appetite, constant nausea, and frequently vomits what little food she eats. During the past six months she has lost flesh fast. On examination there was enlargement of the abdomen, globular in shape; percussion note dull on left side from pubes to three inches below sternum, and two

inches to right of median line. A moveable tumour was distinctly felt occupying the whole of above region. There was dullness in right iliac region up to umbilicus, but no tumour could be felt. Above umbilicus on right side was tympanitic. The following measurements were made. From umbilicus to pubes nine inches, to left superior process, seven and a half inches, to the right seven inches, circumference thirty inches, increased February 12th to thirty-one inches. Digital examination revealed hymen intact as high up as cervix, passed vaginal. Did not introduce sound then, but passed it subsequently and found depth two and a half inches; could not determine size of uterus by bimanual method, the tumour interfering.

My diagnosis was left ovarian cystic tumour. Gave no opinion, but put her on acids and bark, and told her to come for examination every two weeks. On February 12th a physician examined her and pronounced her pregnant, but not agreeing with him, I told her plainly my opinion as to the disease, and that only an operation could cure her, advising her to go to Montreal for that purpose. She then placed herself under the care of another physician, who gave her something to bring on her menses, which served only to increase her weakness, and of course failed in its purpose. In May she came back to me, and on the 12th Drs. Pickup and Vaux examined her and confirmed my diagnosis. She absolutely refused to leave Brockville, as the neighbors had said unkind things of her, and going to the city to be cured would but confirm their suspicions. Her friends and herself wishing me to operate, I consented. An attack of phlebitis in the left leg, which lasted over two weeks, kept her in bed, and prevented her from having the advantage of outdoor exercise. Requiring trocar forceps, etc.. I wrote to my old college friend Dr. Trenholme, of Montreal, for them, and when sending them he stated that he was going to St. Catharines to perform Tait's operation the middle of June, and if I liked, would be glad to stay over a day in Brockville and assist me, and he was kind enough to do so. I determined to operate in my own house, and had two rooms set apart, one for the operation, the other for her to occupy afterward, carefully prepared and cleansed, by washing and whitening walls and ceilings, scraping and brushing all cracks in the floors and filling them with putty, all the woodwork, includ-

ing floors, covered by two coats of paint; the iron bedstead taken apart and thoroughly washed with carbolized hot water, mattresses aired and sprinkled with a solution of carbolic acid, all sheets, blankets, pillows and pillow cases, towels, napkins, etc., carbolised. The sponges were over two weeks in preparing, by being soaked in dilute acid to remove all particles of shell or sand, then boiled in solution of carbolic acid, hung in the sunlight for four days, again boiled same as before, and finally left in a 1 to 40 solution of the acid until wanted. All sutures and ligatures were made antiseptic, as well as everything that would be used or be likely to come near her. June 14th, five days before the operation, she was brought to my house, in order that she might get accustomed to her new surroundings, and also that I could superintend her diet, regulate her bowels, etc. The diet consisted of bread, lamb chops, corn starch, and porridge made of wheat flour. The bowels were moved each day by compound fennel powders. The evening previous to the operation I gave an opiate, in order to lock the bowels and secure rest, and it was unfortunate that it was done, as she was kept awake all night by constant nausea and vomiting, thus leaving her in a state of prostration and weakness that was very undesirable. Daily tepid baths and subsequent oiling, formed part of the preparatory treatment.

On the day of the operation, and half an hour before giving the ether, (Squibbs,) she had  $\frac{1}{4}$  gr. of morphia hypodermically, and fifteen grs. quinine in brandy. I was assisted by Drs. Trenholme, Vaux, Pickup and Jackson. Mr. Robinson, medical student, nurse and servant girl were present, and all of them had their nails, hands and arms cleansed in carbolised water. Spray was not used, but atmosphere was filled with carbolised vapor, and kept at 80° F. The incision extended from left side of umbilicus to the pubes: peritoneum was cut with scissors guided by two fingers. At once, and unexpectedly, there gushed out a quantity of thick, syrupy straw colored fluid, amounting to about six quarts, which ran over the patient to the floor. Dr. Trenholme thought I had accidentally opened a cyst, but such was not the case, as the tumour with its glistening cystic covering came into view at once. Fortunately, there were no adhesions whatever, the growth was from the right ovary, though occupying the left side. The cyst



wall was so thin and fragile, that on endeavoring to draw the tumour into the opening with vulsella, the forceps tore through, easily allowing fluid contents to escape into the abdominal cavity before patient could be turned on her side. The size of the tumour was diminished so as to permit it to be drawn through the opening by inserting my hand and breaking up and evacuating the smaller cysts, of which there were several. The pedicle, which was very short, was tied into two parts by passing a strong silk ligature doubled, through it, cut an inch above and dropped back. The left ovary being diseased was also removed. From beginning the anæsthetic until both ovaries were removed not more than thirty minutes had elapsed, but it took one hour of steady sponging to thoroughly remove all fluid from the cavity. The loss of blood was slight, and no vessels needed tying, forceps having been applied to each, when cut. Twice during the operation the patient became very pale and the pulse almost imperceptible, and two hypodermics of brandy were given. The wound was closed by seven deep silver wire sutures  $\frac{3}{4}$  of an inch apart. Fine silk superficial sutures were passed between. Strips of jute were placed under ends of wires. Several thicknesses of antiseptic gauze were laid over the abdomen, outside of that a layer of marine lint, and all secured by a many tailed bandage. Patient was now put in bed, and rubber bottles filled with hot water placed around her. She recovered consciousness in half an hour, and excepting nausea from the ether, felt well. The highest temperature during after treatment, was two hours after being in bed,  $102\frac{1}{2}$ , pulse, 100. At 6 p.m. temp.  $98\frac{3}{4}$ , pulse, 98. A record of T. and P. taken every three hours was kept for five days, after which they were taken every six hours, but neither ever indicated any serious cause for anxiety. Vomiting was persistent for three days, in spite of every effort to control it, and was finally checked by morphia and atropia under the skin. Before the operation morphia always caused vomiting. Flatus passed on third day. Diet was milk and lime water; catheter had to be used every eight hours for two days, but it caused severe cystitis which gave great trouble to control, producing wakefulness from pain, and frequent desire to urinate. It did not entirely cease until she was quite recovered from the operation. The wound was dressed the eighth day, and was united its

whole length, not one drop of pus having formed. Sutures were removed on eleventh day. The sixth day an enema was given, and afterward a regular movement secured by fennel powder. For three weeks the morning tempt. was  $99\frac{1}{2}$  and the evening  $100\frac{1}{2}$ , and I attributed the rise, partly to the irritation caused by the silk ligatures in the peritoneal cavity. The want of a skilled nurse was much felt during the after treatment, as when absent visiting other patients on three occasions I found her suffering pain with rise of temperature, caused by the stupidity of her attendant. At the end of a week, her tongue, previously thickly furred, became clean, appetite returned, and she enjoyed her food for the first time in more than a year. In thirty days had her taken to her home, she rapidly gained in flesh and is now strong and well.

The presence of such thick, straw colored syrupy fluid in the peritoneal cavity was quite new in the experience of Dr. Trenholme, and I have been unable to find a similar case related in any work on ovarian tumours. The cystic fluid was quite different in character, that in the main cyst being thick and dark in color, while in the smaller cysts it was clear and white. May the presence of the fluid in the cavity of the abdomen be accounted for by exosmosis? It certainly protected the very thin walls of the tumour from the likelihood of being ruptured, which otherwise would readily have occurred from a slight blow or push. Thinking that this, my only case of the kind, might prove of interest to some of my professional brethren, who, like myself, have had little experience in ovariectomy, and hoping that the success met with will encourage others, I have ventured to report it.

#### THE IDENTITY OF YELLOW FEVER AND ACUTE MALARIA—CONSEQUENT CONTAGIOUSNESS OF MALARIA AND CURABILITY OF YELLOW FEVER.

BY VIEIRA DE MELLO, M.D.,

(Member of the Academy of Medicine of Rio de Janeiro.)

Considering that pathologists and physicians of all countries are of one accord in admitting that the "epidemics of yellow fever are always preceded by serious cases of acute malaria," yellow fever

\*Communicated to the Academy of Science of Paris in 1885.

must needs then, in my opinion, express the state of saturation of the atmosphere by the swamp microbe, thus permitting to man a greater absorption, in due time, of the morbid principle, hence the very serious character of the symptoms presented. Considering that the two morbid entities co-exist in the same zone and increase in direct ratio of the development of the malarious germ, — a fact largely observed at Rio de Janeiro where yellow fever is a contemporary and a companion to the excavations, breaking out at the same time that these are effected, and following them in their way through the city; considering, besides, that yellow fever has no distinct characteristics of its own — the symptoms that are ascribed to it being strictly the same that I have observed in serious cases of acute malaria, hæmorrhage, and black vomit included; considering, moreover, and this argument is of surprising value, that morphologically the element considered as productive of yellow fever as shown by Dr. Domingos Freire, is strictly the same that I have met with in the blood, vomit and urine of patients suffering from acute and chronic malaria; considering, likewise, that this very same element has been found by myself in the water that is used for drinking by the inhabitants of places where malaria reigns endemically — places where yellow fever is not even spoken of — an argument that at one time enlightens the etiology of malaria, and overthrows the objections of those who ascribe to pigmental alterations of the hematine, the elements described by Laveron and confirmed by myself; considering, finally, that all the cases of malaria that could have been, and those that were classified as yellow fever, and were attended by me, yielded to the specific treatment of acute malaria — unsuccessful in those in which this treatment is employed, being due, in my opinion, to insufficient doses, bad quality of the medicine used, or tardy interference, when the organism is no longer in a state to absorb it, or because the disease is several days old, or lastly, because the attack has been so violent as to cause the same deep disorders that in milder cases would take time to make their appearance. I have come to the conclusion that yellow fever is a graver modality of acute malaria, its superlative gravity; that, therefore, it is not an idiopathic morbid entity, as has been asserted until now, but the expression of gravity in another morbid state, and that the name yellow fever

should be changed to that of grave malaria, this qualification serving to designate the highest intensity of malaria.

Amongst the objections that can be made to these doctrines, objections that have already been presented to me, the one that seems most weighty is the following: "Yellow fever cannot be of the same nature as malaria, since the first is contagious and the second is not." This is a great mistake. In the first place, no one, to my knowledge, has been able to demonstrate the contagiousness of yellow fever, that is the transmissibility of the disease from body to body, by contact; in the second place, because malaria is susceptible of being transmitted by any individual to persons surrounding him, as well as of being transported to great distances. For instance: An individual is poisoned by the helococcus, and retires to his rooms, where he remains for several days without appropriate medication. The helococcus, not being consequently attached, and finding in the organism of the patient a favorable field for its development, proceeds on its evolutionary march. The patient, though whose excretory apparatus works, discharges continually from his body a certain quantity of these microbes that are thrown into the surrounding air, where, if they meet with favorable conditions of vitality, they live, develop and procreate. Therefore, after a certain time the rooms of this individual will be transformed into a genuine focus or nursery of helococci, and consequently whoever enters there may receive the same morbid element that is found in a marsh or swamp.

Here we have the explanation of the contagiousness of yellow fever, because it is at the same time the explanation of the contagiousness of malaria, a question that has been despised, why I cannot tell, when it is a known fact, as no one dares to deny, that malaria is a microbiotic disease. Thus, an individual that has been infected in a marsh, may, in turn, constitute another marsh focus or nursery as long as his organism affords to the helococcus the necessary conditions for its development and procreation. And if such a case is liable to happen in reference to one single indi-

(1) Έγος, swamp, marsh and λóχκος, in Latin *coccus*, *coccum*, a germ, a seed, a small round body. This denomination created by myself to designate the microbe of malaria, is based on the rules established by Egger for the construction of neologisms.

vidual, it is much more liable to happen in places where the accumulation of patients is considerable, especially if the enteric form of malaria prevails, if hygienic rules are neglected, or if the faecal matters are retained or thrown in the vicinity of these places.

### Selected Articles.

#### LOCOMOTOR ATAXIA—AMYOTROPHIC LATERAL SCLEROSIS—LATERAL SCLEROSIS.

CLINIC BY H. C. WOOD, M. D., PHILADELPHIA.

GENTLEMEN, this patient comes to us with the statement that every two or three weeks, or sometimes at longer intervals, he has frightful attacks of abdominal pain accompanied with vomiting. Under these circumstances, attention is naturally directed to the condition of the stomach. We learn that these attacks are not provoked by any error in diet, that they are apparently spontaneous, and that between the attacks there are no symptoms of dyspepsia or indigestion. The attacks are exceedingly violent. The patient came to the hospital two weeks ago. When I first saw him, he appeared to be suffering from no severe symptoms. A day or two later, I found him in bed, groaning and moaning as though in agony. There was frequent vomiting of mucus tinged with bile, or of a liquid so thin as scarcely to be called mucus. These attacks of pain with persistent vomiting lasted three or four days and kept the man from sleeping, in spite of the free use of opium. Such attacks are evidently not dependent on irritation of the mucus membrane of the stomach.

The pain would suggest the passage of gall stones. Careful examination, however, shows that the pain lacks the sudden cessation which is characteristic of biliary colic. It is a steady, unbearable pain, lasting for hours and days and unaccompanied with jaundice, disturbed digestion, or any other manifestation of the passage of biliary calculi. You will call to mind the case of the woman with attacks of pain, similar to these, occurring in the rectum, which I showed you last week. When you have brought to your notice a case of horrible, recurring, violent, unaccountable pain, remember the possibility of its being one form of crisis occurring in locomotor ataxia. Sometimes these paroxysms of intense, shooting, darting, tearing, boring pain attacks the genital organs.

When I found this man sitting at his bedside, my attention was at once directed to his pupils. I found that they were very small, in other words, he had a distinctly myotic or contracted pupil.

When I shut off the light with my hand, I found that the pupil did not dilate. It was, indeed, insensible to light. I then tried the pupillary reflex, but there was no dilatation of the pupil produced by pinching the skin of the neck. Then I asked him to look at my finger held close to his face and a moment later to look at a distant object, and found that the pupil which was immovable to light, and responded not to peripheral irritation, reacted normally to the movements of accommodation. Our patient has, therefore, that comparatively rare pupil known as the Argyle Robinson pupil, because first described by that gentleman.

Before going further with this case, I wish to say a few words in regard to conditions of the pupil as seen in nervous affections. We have as the afferent nerve, so to speak, going from the eye to the centre within the brain, the optic nerve. We have two centres, connected as motor centres with the pupil, the oculo-motor centre and the spinal dilating centre, situated high in the neck. What happens when a person's neck is pinched? An impulse is sent through the sensitive nerves which reaches the cervical centres, lying in the upper part of the spinal cord. As a result, there goes out from the cervical sympathetic ganglia, an impulse causing dilatation of the pupil.

Again, the pupil contracts with exposure to light, and dilates when the light is withdrawn. This is especially accomplished through the oculo-motor centres. The optic nerve is the afferent nerve. Its fibres run through certain centres in the neighborhood of the thalamus opticus and then pass down to the corpora quadrigemina and oculo-motor centre. As a result of exposure to light, there is oculo-motor stimulation and the pupil contracts.

Then as to the movement of accommodation. When a near object is looked at, the eyes are brought convergent as to their axes, and at the same time, the pupil contracts and the shape of the lens is altered for the purposes of distinct vision. These are so-called simultaneous or associated movements, that is, movements which habit or the original construction of the nervous system has brought about as always being performed together. They apparently take place through the oculo-motor centre. An impulse from the upper cortical region of the brain is sent down to the oculo-motor centre for the act of accommodation, and the centre sends out an impulse which contracts the pupil, and at the same time, converges the eyes.

Besides these various movements of the pupil, there are others associated with emotional conditions, but we have been unable to study these in this case.

In the Argyle Robinson pupil, there is want of response to light and to reflex irritation from the skin, but the pupil does respond to alterations of

accommodation. Wherever this pupil is found, there is almost of necessity serious organic nervous trouble, and the probabilities are always in favor of the idea that the patient is suffering from locomotor ataxia. The Argyle Robinson pupil has, however, been found in a certain number of cases of general paralysis of the insane, and perhaps, in a few other diseases, but it marks especially the presence of locomotor ataxia. Where in any given case, as here, there exists violent gastric crisis, along with the presence of the Argyle Robinson pupil, you have even without further examination, sufficient grounds for the diagnosis of locomotor ataxia.

The explanation of this peculiar condition of the pupil is not difficult. We know that the optic or afferent nerve is perfect because the patient sees. There is no evidence of paralysis of the oculo-motor nerve and the pupil is contracted. Supposing the man to be suffering with locomotor ataxia, it is plain that the reason why there is no response to light is that the fibres which connect the optic centre with the oculo-motor centre are involved in the diseased structures.

There is interruption of the pathway and there can be no passage of the impulse from the centre of the optic nerve to the oculo-motor centre. The reason that the pupil does not respond to peripheral irritation is because the sensitive nerve connected with the upper spinal region is also involved in its passage through the cord. You will remember that, in locomotor ataxia, there is a chronic inflammation and sclerosis or hardening of the posterior column of the spinal cord, and hence these sensitive fibres are cramped and squeezed and their function abolished. When the skin is irritated, no impulse reaches the centre. It is interesting to observe in connection with the gastric crises, these other signs that the disease is high up in the spinal cord, even in the medulla, for the medulla, although placed within the skull for purposes of protection is nothing more than the upper part of the spinal cord.

When the man is examined further, other evidences of locomotor ataxia are found. In the first place, he has lost the patella reflex. He has darting and shooting pains through the legs, unaccompanied with soreness, or with pain on motion. Remember that bilateral, darting shooting pains, without soreness and without pain on motion, are in nine cases out of ten, if they are persistent and not due to gout, the result of locomotor ataxia. When with this there is loss of the patella reflex, the diagnosis is almost positive. I have also found some disorder of coördination in this case. The man has somewhat ataxia gait. He walks with the feet spread wide apart so as to give a firm base of support. The movement of the legs are irregular. With some difficulty he can stand on both legs with the eyes shut, but is unable to stand on one foot with the eyes shut.

We are therefore able in this case to arrive at a positive diagnosis of locomotor ataxia.

Leaving this case for the present, let me briefly call attention to the various forms of local inflammation of the spinal cord with which we meet in practice. In the so-called system diseases of the cord, the scleroses or chronic inflammation involve certain tracts of the cord, running up and down, but do not invade widely scattered foci. In the centre of the cord is the gray matter. Then we have the lateral tracts. In the centre of the anterior portion of the cord is a small tract which corresponds to these lateral tracts physiologically. Then we have the posterior median columns or the columns of Goll. So far as system diseases are concerned, we know of two scleroses especially, which produce definite symptoms. In the first place the posterior region may be involved, especially the region where the posterior nerve roots emerge, constituting *locomotor ataxia*. In the second place, the lateral columns of the cord may be affected, constituting *lateral sclerosis*. There are one or two cases in which the symptoms have been said to have been due to sclerosis confined to the columns of Goll. This is, however, rare, and I have never met with such a case. In the anterior portion of the gray matter there are certain groups of large cells. These are the motor cells whose function it is to convey the nervous impulses which shall cause contraction of the muscle, and it is also their function to preserve the nutrition of the muscle. When a muscle is cut loose from these cells it wastes and its electrical reactions change. When this portion is diseased, we have, if the affection is acute, infantile paralysis or acute muscular atrophy; if it is chronic, we have progressive muscular atrophy. When in spinal affections, there is rapid wasting of the muscles and rapid changes in the electrical reactions, there is disease of these cells; whatever else may be present in the spinal cord these cells are involved.

There is an affection of the spinal cord, in which there is disease of the lateral columns associated with disease of these motor cells. This is known as *amyotrophic lateral sclerosis*.

In the consideration of the case before us, I have called attention to most of the symptoms of locomotor ataxia. They are disorders of locomotion and coördination, and pain without loss of motor power or wasting of the muscles.

Let me now call attention to this second case which represents another form of spinal affection, namely, lateral sclerosis. The symptoms of locomotor ataxia are sensory and afferent. The lack of the power of coördination is due to the failure of afferent impulses to reach the brain. In lateral sclerosis, the symptoms are disorders of motion, but not of nutrition of the muscle, nor of sensation. There is no wasting of the muscle and no lack of

coördinating power. There is simply disorder of the motor function of the muscle. These are chiefly the result of irritation, so that there is more or less permanent spastic muscular contraction. With this there is excitability of the reflexes with a certain amount of loss of power, because whilst the fibres are irritated, there is also interference with the passage of currents down from above.

This case exhibits the symptoms of lateral sclerosis. Although I lift the leg and support it at the thigh, there is no bending at the knee, and it requires considerable force to flex the leg. Tapping the tendon of the patella, I find that the patellar reflex is abnormally increased. I cannot at this time develop ankle-clonus, although it has been noted in this case. There is, then, excessive rigidity, increased reflex activity, and, in addition, a peculiar gait. When the disease is fully formed, the gait is characteristic. The patient cannot get his toes from the floor, owing to the spasm of the calf muscles. Examining the legs, no muscular wasting is found. The electrical reactions are normal. The arms are sometimes affected in lateral sclerosis, but in this patient the stiffness is very slight at the arm. There is, however, great loss of power in the arms. On exploring the arms, fibrillar contractions are noted as abundant. These are never seen in pure lateral sclerosis. Moreover, there is great wasting of the shoulder and arm muscles. These symptoms, we are told, came on gradually, they are evidently due to disease of the motor or anterior cells of the gray matter of the cord, and we have an instance of the chronic spinal disease, known as *amyotrophic lateral sclerosis*.

Turning now to the third patient, we find the following history. This girl is twenty-six years of age. She was in good health until three and a half years ago, when she developed the symptoms with which she now suffers. The affection has come on gradually. There was, she stated, at one time partial loss of power in the left arm and leg, and she was unable to work for four weeks. She then obtained an easy place and returned to work.

You observe the same stiffness of the legs, seen in the previous case. When I raise the thigh from the bed, there is no flexion at the knee. The muscles of the calf are contracted. The patellar reflex is increased. There is some rigidity of the arms, most marked on the left side.

We have then, in this case, either lateral sclerosis or something simulating it. There is an affection known as hysterical contracture, in which there is loss of power, with heightened reflex activity, rigidity, or more or less permanent contraction of the muscles, a disease which very closely simulates lateral sclerosis, and in some cases it is almost impossible to make the diagnosis. Two years ago I had a case in the Philadelphia Hospital which well

illustrates the difficulty in diagnosis. This woman suffered with Pott's disease of the vertebrae, which had produced angular curvature. It is not uncommon to have secondary sclerosis following the transverse myelitis of this affection. With a pronounced history of disease of the vertebrae, there were the typical symptoms of lateral sclerosis and an almost entire absence of hysterical indications. The diagnosis of lateral sclerosis was made. On one occasion, she was given some powders of bismuth for a slight derangement of the stomach, and she began to rapidly improve, so that in a few days, instead of being confined to a rolling chair, she was able to walk about. That was largely a case of hysterical contracture.

This woman before us is not distinctly hysterical. If in a decidedly hysterical patient you have symptoms like these, especially if they have developed suddenly, the probabilities are that you are dealing with a case of hysterical contracture. Although this patient is somewhat nervous, she is not distinctly hysterical. The disease has come on slowly. Hysterical contractures are more apt to come on suddenly, but not necessarily so. This woman has another symptom which I believe is characteristic of organic disease, and at present, I should always make the diagnosis when I found it distinctly present. During the past two months she has complained of having the feeling of a bandage around the waist. This she spoke of herself. Of course if you ask an hysterical patient if she has a band-like feeling around the waist, she will be very apt to say that she has, when she had never dreamt of it. Another point I wish to allude to, and that is, that chronic nervous diseases, especially in woman, are often associated with hysteria. If any one of us were shut in a room for months, and months, over-shadowed by a great cloud of approaching troubles, it is probable that we would develop hysterical symptoms. The point is always to be borne in mind, that underlying the hysterical manifestations, there may be a real organic trouble.

There is in this case, a slight inequality of the pupils. Everything, therefore, points to the existence of lateral sclerosis, and the prognosis is unfavorable. We should, however, not pronounce a too positive prognosis, but should leave a way of escape in case the condition should prove to be largely hysterical. *Boston Med. Journal.*

#### THE MODERN TREATMENT OF UTERINE MYOMA.

The following quotations are from Lawson Tait's article, under the above heading, in the *British Medical Journal*, with notes by W. J. Sinclair: "The first point of my thesis is to show that the removal of the uterine appendages for myoma, when properly performed, is not a fatal operation, but one with hardly any mortality at all, even

when the tumors are large, and when the patients are brought almost to death's door by hemorrhage." To support these statements the author reports 58 cases operated upon since January, 1884, without a single death. In the series published up to the end of 1883, there were 50 cases, with two deaths. It is the author's belief that in experienced hands "the real mortality of the operation" is not more than one per cent.

The second point which Mr. Tait seeks to prove is that the results of the operation are satisfactory and permanent, so that it may be confidently recommended for the relief of suffering and the saving of life. With this object he gives brief notes of the more recent history of each case in his first series of 50. Looking back through a period of 4 to 13 years, he shows that the result was satisfactory, but with two exceptions. In one of these there was a mistaken diagnosis, and in the other the hemorrhage continued and the tumor did not cease to grow, yet in both cases the operation gave some measure of relief. Mr. Tait's results in both series are so brilliant that the reader hardly requires the argument which succeeds the statement of facts. He claims on the two points of his thesis (1) that the primary mortality of this operation is so low that it can be justified far more decidedly on that score than any other of the serious operations of surgery; and (2) "the secondary results of this operation are as brilliant as those of any other operation in the whole realm of surgery with which I am acquainted." After the publication of this paper, if any doubted before, it will probably be conceded that Mr. Tait has made good his position with regard to the operation. He may be pardoned, perhaps, for recalling the incidents connected with the publication of his first results, even if it reminds some of the facts which they would rather forget. The history of the rejection of Mr. Tait's paper by the Royal Medical and Chirurgical Society of London, its publication in the *American Journal of the Medical Sciences*, and the subsequent vicissitudes of the operation, constitute a lesson in liberality of judgment, if not in surgery. The conqueror, however, can now well afford to have uttered his *ca. ri. etis* for the last time.

The author discusses the question of priority of discovery, or priority in introducing the new proceedings. While he shows that he and Hegar and Battey were almost simultaneous in the performance of the operation, he claims to have been the first in the field by about six months. These historic facts are well worthy of the closer attention of British surgeons, especially of those who speak of "Battey's operation" when they do not call it "spaying."

Mr. Tait next turns his attention to the relative value of enucleation and hysterectomy, and he thoroughly condemns both operations. He seems

to be of opinion that enucleation is completely discredited and ought never to be performed, whilst hysterectomy is to be resorted to only in neglected cases, or in the very few exceptional cases in which the growth is not arrested by the removal of the appendages or by the menopause. "If the removal of the appendages were performed on patients early in the history of these cases, as it ought to be, very few indeed would arrive at the necessity for the operation of hysterectomy."—*Medical Chronicle*.

**EUCALYPTUS IN TYPHOID AND OTHER FEVERS.**—Dr. Leighton Kesteven, contributes his observations in this subject to May No. 1885, of *The (London) Practitioner*.

While treating cases of typhoid fever in the Brisbane General Hospital, the idea occurred to him that the oil of eucalyptus would be efficacious. In the next 18 months he treated 220 cases of the fever with it, with only four deaths, and these four cases would probably have died from other causes than the fever. His dose is now about ten minims every ten hours. It does not agree well with all stomachs when given simply with mucilage; but trouble in this respect can be entirely overcome by first carefully emulsifying the ten drops of oil with mucilage, and then the addition of a half drachm each of aromatic spirits of ammonia, spirits of chloroform and glycerine—the latter entirely removing the rough semiresinous taste of the oil.

This medicine acts, *first*, by steadily and permanently reducing the force and frequency of the pulse, indeed acting with marvellous rapidity in some cases; *secondly*, by lowering the temperature, which occurs less rapidly and may be secondary to, and dependent on the lowering of the pulse; *thirdly*, by the beneficial effect on the tongue—almost immediately alleviating the distressing dryness so universal in typhoid fever, and removing the thick brown coating, leaving, relatively, but little fur, frequently cleansing the tongue entirely in a very short while; and, *fourthly*, the skin becomes moist and soft, giving comfort to the patient.

The Doctor also puts great faith to the liberal use of whiskey from the beginning of attack—even as much as 30 ounces in the twenty-four hours. Ordinarily, he feeds on milk thickened with isinglass, beaten up eggs, milk and soda, cocoa, and—where diarrhoea exists—ground rice and milk. In asthenic cases ounce doses of chicken broth (concentrated to ten ounces from a whole fowl) every half hour or longer, the juice of half cooked mutton, or beef tea made in a pot without water strained through a fine muslin should be used. For the abdominal tenderness, apply ice-cold compresses, and allow ice to suck. Apply ice to the shaved head for cephalalgia, and use frequent cold "packs" from head to knees if temperature rises. Change the bed linen night and morning without

letting the patient get out of a horizontal position.

The Doctor thinks probably the eucalyptus acts as a germicide. In most cases, the fever is entirely over in ten or twelve days, although he keeps his patients in bed the traditional three weeks.

Experimentally, he has used eucalyptus oil in two or three cases of pneumonia, with the most marked benefit.

**TREATMENT OF PULMONARY CONSUMPTION, DA COSTA.**—*Hygienic Treatment.*—Out-door exercise, good food, warm clothing; climate of paramount importance. The best climate, by far, is that found in Egypt; Algeria is a good place. In this country, New Mexico, Southern California, South Carolina, Thomasville in Georgia, Florida, Colorado, for some cases, is an excellent climate. Cases having a co-existing bronchitis do better in a damp and mild climate, as Florida, etc. The element of change is very useful. The Adirondacks is a fine place for those early cases in which there is no tendency to hemorrhage. Prof. Da Costa does not care much for the "milk diet," but allows it in conjunction with other things. Give plenty of meats, and alcohol in moderation, especially in those cases free from fever. Mix it with ol. morrhuae, to lessen the tendency to its abuse. Whiskey and brandy are the best stimulants here. You need not interdict smoking.

*Medicines.*—Ol. morrhuae is of great utility by improving nutrition and also by affecting the tubercle. Do not use its substitutes, as glycerine, etc. Give f̄ss. ter die, one hour after meals. To disguise it, and to promote its ready absorption, give ℞x-xv ether, but this sometimes causes belching. Mix it with equal amount of malt or whiskey. When the appetite fails stop its use for a while. Do not permit the oil to be taken in hot weather.

Next in importance is arsenic in small doses in the early stages; arsenious acid, gr.  $\frac{1}{60}$  or gtt. iij Fowler's solution, ter die. In the late stages it will be of no avail.

A third remedy is iodine: it should be more generally used; liq. iodi comp. gtt. i-ij, ter die, with potassium iodide to alternate with it. When anaemia is present, and not much fever, use iodide of iron. It is very valuable. Push it up to the point of tolerance. Begin with gtt. xv of the official syrup, and push up to f̄sj, ter die.

Prof. Da Costa does not like the hypophosphites. They have no special effect, as ol. morrhuae and arsenic. Inhalations of sodium benzoate are of no use. Carbolic acid and tar by inhalation are of some avail.

*Treatment of Special Symptoms.* Entirely too much is done for the symptoms. For cough we should have no expectorant, unless bronchitis exists. Since the cough is generally an irritative one, morphia must, in time, be given. Codeia, gr.  $\frac{1}{4}$ , in simple elixir, often has a wonderful

effect and does not constipate. Prussic acid or fluid extract of wild cherry is very useful at times. We may combine the acid with morphia. Inhalations of oil of eucalyptus give relief.

*Night Sweats.*—Give atropia, gr.  $\frac{1}{80}$ , at bedtime. Sponge off the body with hot water to constrict the vessels. Infusion of sage at night. Mineral acids, especially sulphuric acid. Zinc oxide, gr. ij ter die. Ergotin or fluid extract of ergot is better than morphia in some respects. It is more permanent and does not cause dryness. Give ergotin, gr. ij, ter die, the last dose at bedtime.

*Digestive System.*—The patient often has vomiting. Two excellent remedies may be given, as carbolic acid or creasote, gr.  $\frac{1}{4}$ , four times per diem. Strychnia, gr.  $\frac{1}{30}$ , ter die, is also of great value.

*Diarrhoea.*—Opium, bismuth ℞j; copper sulphate, gr.  $\frac{1}{2}$ ; silver nitrate, gr.  $\frac{1}{4}$ , etc.

*The Throat in Phthisis.*—It may be swollen, and the larynx the seat of ulcers, which may become tubercular. Drink demulcents, as Irish moss (5j to the Oj).

Prof. DaCosta has confidence in local applications of iodoform and cocaine. Let the patient eat his meals while the parts are under the effect of cocaine.

*For Irritative fever—*

R. Quininae sulph.,	gr. iss
Digitalis,	gr. ss
Opil,	gr. $\frac{1}{4}$ . M.
Ft. pil.	

Sig. — Ter die.

*Col. and Clin. Record.*

**TREATMENT OF CROUPOUS PNEUMONIA, DA COSTA.**—Do not bleed, as a rule, though in a strong man with strong pulse you will relieve the headache and dyspnea in the early stage. In later stages a few wet cups, in the same condition, will be of much avail. Keep down the circulation at any rate, by one of two remedies, to wit; Tinct. aconite, ℞j-ij, in diaphoretic mixture, every two hours, or tinct. veratrum viride, ℞ij-v, in syrup of ginger, until an impression is produced on the pulse. In conjunction, quinine, gr. viij-xij per diem, will be found beneficial.

As the case goes on, and the circulation is to be further controlled, the use of digitalis is indicated. Act on the secretions and keep them up; keep patient quiet. Give him Dover's powder at night.

Quinine is to be given throughout the course of the disease. In the second stage expectorants are valueless, but may be used later, when tissue breaks down, etc. Then use ammonium chloride or ammonium carbonate. The latter is also a stimulant to the circulation, and also breaks up exudation. Give it in doses of gr. v-vij, every two or three hours. The aromatic spirits of ammonia



may be substituted for it, in doses f ss. given in simple elixir.

Plain food should be given: oysters or fluid food. We may give him almost what he wants. Stimulus is required for the symptoms, but not for the disease: *i. e.*, a flagging pulse, a weak heart, call for whiskey. In this state of affairs give f3ss every two or three hours. If the case passes into the stage of general exhaustion give whiskey freely.

In typhoid pneumonia give ammonium carbonate, quinine, digitalis and stimulus from the very onset.

**Local Treatment.** If some pleurisy exists poultice, but cease when pain stops: glycerine for circumscribed pleurisy and lingering consolidation. — *Col. and Clin. Record.*

**CLASS-ROOM NOTES, PHILADELPHIA.** In all cases of *tape worm*, at the clinic, Prof. DaCosta uses pelletierine.

Prof. Parvin, following the recommendation of Playfair, says that "chloral is peculiarly useful in cases of *rigidity of the os uteri* primiparæ." He gives gr. xv to ʒj every hour or so until three or four doses are taken.

A case of *chorea*, in an anæmic girl, æt. 8, which followed diphtheria, was presented by Prof. DaCosta. The choreic movements were continuous. Rapid improvement followed the treatment, which consisted in—

R	Arsen. chlorid.,	ʒr 1 <sup>1</sup> / <sub>2</sub>
	Tinct. ferri chlorid.,	ʒtt.v
	Syrupi simplicis,	ʒi. s.
	Aque. ad	f5j. M.

Sig.—Ter die, after meals.

Prof. Gross gave the following directions for making *koumiss*, which he states is an excellent article of diet when the stomach cannot tolerate food:—

Grape sugar,	ʒss
Water,	f5iv. M.
Milk,	f5ij
Fleischmann's yeast,	ʒi M.

Mix the two Rs in a quart bottle, and then fill the bottle with milk: cork securely: shake ter die, and on third day use. A quart may be used in twenty-four hours. In catarrhal conditions of the stomach it is most agreeable. — *Col. and Clin. Record.*

**SUBCUTANEOUS INJECTION OF THE SALTS OF QUININE.**—The occasional necessity for the injection of quinine subcutaneously, not only in severe malarial affections, but also for antipyretic purposes, must have compelled many physicians to reflect on the best methods of avoiding the disagreeable consequences which too often follow such a use of most of the salts of that drug.

It is generally in violent and pernicious malarial

complaints, in which both the stomach and rectum are so irritable that medicines are not retained long enough to permit of its satisfactory absorption into the system: or where, without such irritability there is some mechanical obstacle to the administration of food and medicine by the mouth, and we wish to reserve the rectum for the purpose of nourishing the patient; and occasionally, too, in a few cases of hyperpyrexia, in which the danger from excess of heat is imminent, while other methods of reducing the temperature are contra-indicated, and every minute is of value, that resort must be had to the hypodermic injection of such powerful antipyretics as quinine, in quantities likely to produce a rapid fall of temperature. There are probably great differences of opinion as to the doses required under such circumstances, but I have thought it necessary, more than once, to put as many as thirty grains of quinine under the skin in a few hours' time. As it is scarcely possible to inject more than five grains at any one point—smaller doses indeed, such as two or three grains, being distinctly preferable—the number of injections and the pain produced are matters of no small importance. The method I have latterly adopted has given decidedly better results than any previously tried, and can be stated in a few words. The two best salts of quinine to use are the bisulphate and the hydrochlorate. Both are fairly soluble without acids, but the bisulphate has the advantage of being considerably cheaper. One grain of that salt will dissolve readily in six minims of equal parts of the purest glycerine and of distilled water at the temperature of the body, and when thrown at that temperature into the looser subcutaneous cellular tissue—the only part into which quinine should be injected—will be rapidly absorbed without deposition of any crystals of the drug. To this solution two per cent. of pure carbolic acid must be added. Thirty minims of such a solution, containing five grains of the bisulphate, may then be used for one injection from a syringe of double the average capacity—now, as a rule, just about fifteen minims; and although it is probably better, as previously mentioned, to inject less at one point, no local or general injurious effects have followed the numerous applications of the maximum quantity stated, which have been made since I have been in the habit of adding the carbolic acid to the diluted glycerine solution of the quinine. The local anæsthetic action of the carbolic acid, too, is unquestionably of great value in diminishing the pain attending the hypodermic use of such an irritating medicine as quinine. — *British Medical Journal.*

**THE TREATMENT OF ERYSIPELAS.** The treatment of what has usually been termed idiopathic facial erysipelas is of interest both on account of the frequency of the disease and the failure in many

cases of the usual means to control it. Many authorities firmly believe in the malarial origin of this disease, and hence quinine, when combined with the tincture of the chloride of iron, occupies a leading place as an internal remedy in the abortive treatment of erysipelas. But the local symptoms, relief of the burning pain, limiting the extension of the disease, and thus preventing invasion of important organs, require prompt and constant attention. Dr. Daniel Lewis, (*Journ. Cutaneous and Venereal Diseases*, September, 1885) condemns the use of old lead and opium wash as a vile smelling and appearing preparation, and one which he believes to be very little more efficacious than plain cold water. He further believes that the solution of carbolic acid and oleic acid, in the proportion of 1 to 8, as proposed by Dr. Jacobi, has also the disadvantage of causing considerable irritation of the healthy skin, besides being extremely disagreeable to the patients. Dr. Lewis believes that the object to be aimed at is the use of some dressing which will combine compression of the part together with exclusion of air, and while collodion fills this indication, ordinary white-lead paint is in his opinion much more satisfactory. The method of employing this treatment is to paint the parts thoroughly with white-lead paint, dressing the wound, if there be any, by cotton-wool saturated with boro-glyceride. The pure white lead of the shops is likely to dry too slowly, and it is, therefore, advisable to add some "dryer" as in ordinary painting, which in no way changes the effect of the application.\*

The paint should be thicker than for ordinary use; when desquamation begins it peels off readily, even when applied to the head. Dr. Lewis states that he has frequently employed this mode of treatment, and that it serves at once to relieve the burning pain; recovery often takes place with a single application. It is equally applicable to idiopathic and traumatic erysipelas, and even in hospital cases. *Therapeutic Gazette*.

**PHOSPHIDE OF ZINC IN DYSMENORRHOEA AND STERILITY.**—In Matthew Duncan's lectures on Sterility in Women, he places dysmenorrhœa in the list of the best demonstrated sources of, or attendance on, such conditions. But, even if we consider dysmenorrhœa the cause of the sterility, the question of the treatment of the menstrual difficulty does not in many cases admit of ready answer. Certainly, there are cases of dysmenorrhœa which may be rapidly and satisfactorily treated by dilating the cervical canal, this dilatation being by double-bladed dilators, rather than by other means. But there remains a large number of cases that present no indication for this method of treatment, and which, of course, are not benefited if it be tried.

\*The composition of this "dryer" is not generally known, as it is a patent preparation. It appears to be some kind of resin dissolved in linseed oil.

Now, some of these may possibly be cured by the use of phosphide of zinc, as recommended by Decoux in a recent number of the *Gazette des Hôpitaux*. Having found this medicine useful in many cases of dysmenorrhœa, and of amenorrhœa. Decoux narrates a case where it twice proved effective in curing sterility associated with the former disorder. In addition to the success of this medicine in dysmenorrhœa, amenorrhœa and sterility, he has found it remarkably useful in cases of hysteria, ataxia, anæmia and neuralgia. He gives two granules of four milligrammes each, morning and evening. Only the crystallized preparation should be used, as the powder is inert. He states that its preparation is so difficult, that, with a single exception, one scarcely finds in commerce any but an impure product, which is partly or completely ineffective.—*Med. News*, September 5, 1885.

**THE BEST DISINFECTANT FOR THE HANDS.**—A thoroughly efficient disinfection of the physician's hands, remarks the *Therapeutic Gazette*, is more than a matter of personal cleanliness: it is an absolutely required, though often neglected, protection of his own person and the safety of his family, friends, and patients. There being no dissenting voice as to the necessity of this by no means irksome precaution, the only question that can arise in this respect is, What method of disinfection insures the greatest success? The present state of bacteriology must convince even the most sceptic and conservative physician that soap and water exercise not the slightest influence over the microbial organisms, and that the true antiseptic agents have to be resorted to.

Forster, of Amsterdam, made some special researches in this field (*Pharm. Centralblatt*, May 28, 1885) with the view of ascertaining the relative worth of carbolic acid, boric acid, chloride of zinc, and iron. He gained the conviction that the ordinarily used two and one-half per cent solution of carbolic acid, and even Billroth's plan to wash the hands in muriatic acid and ten per cent phenol in glycerine, were insufficient to sterilize the hands, that is, prevent microbic growth on them. The only procedure which Forster found absolutely reliable was the one recently recommended by Koch, of Berlin, which consists in a solution of corrosive sublimate having a strength of seven to fifteen grains to two pints of distilled water. The simplicity of the manœuvre and its unquestionable prophylactic power will go far to recommend Koch's wash to the American practitioner.

**TIMELY WORDS.**—The exigencies of practical teaching in our medical schools tend to hinder any marked attention to the individuality and common humanity of the patient. As a result, there is a rather wide-spread propensity on the part of students and junior practitioners, especially in hospitals, to

look upon the patient in hand, not as a sentient and suffering fellow-creature, but as a more or less interesting incarnation of disease.

In the course of a recent address, Prof. Osler made the following admirable plea for the recognition of the human element in all patients—a plea most opportunely addressed to an entering medical class: “In your dealings with patients, public or private, there is but one law to regulate your conduct: ‘Whatsoever ye would that men should do unto you, even so do unto them.’ Kindness of disposition and gentleness of manner are qualities essential in a practitioner. There is a tendency among young men about hospitals to study the cases, not the patients, and, in the interest which they take in the disease, to lose sight of the individual. Strive against this. Realize, so far as you can, that the mental state of the patient enters into his feelings, bear with his complainings, and scan gently his faults. The kindly word, the cheerful greeting, the sympathetic look, trivial as they may seem, help to brighten the paths of the poor sufferers, and are often as ‘oil and wine’ to the bruised spirits entrusted to our care.”—*Medical News*.

**MEDICAL NOTES.**—In *chronic gastric catarrh*, a pill, as follows, was given by Prof. Da Costa:

R. Argenti nitrat., . . . . . gr.  $\frac{1}{4}$   
Ext. belladonnæ, . . . . . gr. 1-16

Sig.—Ter die, . . . . . M

After passing a catheter, to relieve a man of *retention of urine*, Prof. Brinton gives, usually:

R. Tinct. opii camph., . . . . . f5 ij  
Quinina sulph., . . . . . gr. x. M.

Sig.—Take once, after operation.

Several times Prof. Da Costa ordered the following combination for *constipation*:—

R. Ipecacuanhæ, . . . . . gr.  $\frac{1}{4}$   
Rhei, . . . . . gr. ij  
Ext. colocynth. co., . . . . . gr. j.

Ft. pil.

Sig.—At bedtime.

For a case of *hysteria*, Prof. Bartholow gave

R. Mass. ferri carb., . . . . . gr. v  
Liq. potassii arsenitis, . . . . . gtt. ij  
Mucilaginis, . . . . . q. s. -M.

Sig.—After meals. Also tinct. nucis vomicæ, gtt. x, before meals.

For a case of *flatulent dyspepsia*, Prof. Da Costa advised the following course of treatment:—Milk and under-done meats—nothing starchy—sacch. pepsin, gr. v, with meals, also a pill of—

R. Argent. oxid., . . . . . gr.  $\frac{1}{4}$   
Ext. nucis vomicæ, . . . . . gr.  $\frac{1}{8}$   
Pulv. capsici, . . . . . gr.  $\frac{1}{8}$

Sig.—Ter die

A pill of aloin, gr. 1-10, every night, for accompanying constipation.

Prof. Da. Costa, when advising the chloride of gold and sodium, for *interstitial nephritis*, at the hospital, at one of the recent clinics, told of a physician suffering from this disease to whom he recommended this remedy and who now declares that he is entirely cured.

Prof. Bartholow recommends the following *solution for hypodermatic use*:

R. Ergotine (aq. ex.), . . . . . 5j  
Glycerini, . . . . . f5j  
Aque dest., . . . ad . . . . . f5j -M.

Sig.—8 minims = gr. j of ergotine.

*Col. and Clin. Record*.

**ATONIC DYSPEPSIA.** G. J. Preston, M.D., Professor of Practice of Medicine, Baltimore, finds that atonic dyspepsia is by far the most common form of indigestion met with at the Polyclinic. The alkaline treatment, even in cases where acidity was marked, was soon discarded as being only temporary. Sometimes the combination of a simple bitter, as tincture of columbo with soda bicarbonate, acts well for a time. Pepsin has proved of little value in adults, unless given in quantities larger than most dispensaries can afford, or than a patient will take.

The most generally useful drug is strychnia in the form of tincture nux vomica. This can be given in much larger doses than it is prescribed. For many of the cases the initial dose was gtt. x to xx. t. i. d. with as much acid hydrochlor. dil. This given before meals in cases where the normal acid is in excess, and after meals where it is deficient in quantity, is of inestimable service. It is by no means a new treatment, but after a careful and extensive experience with it, it has proved the most satisfactory. In some of these cases where, in addition to the ordinary symptoms, there is pain, a very good plan is to add to the above, m. i. to iii. of acid hydrocyanic dil. This drug seems to have peculiar sedative action upon the terminal nerves of the stomach, and will be found useful in various painful affections of this organ. Many of these cases improve rapidly on iron, and the best way to overcome the unpleasant effects which often prevent its use, is by combining gr. x of pot. brom. with gtt. x. to xx. of the tincture of the chloride.—*Id. Med. Jour.*, Aug. 15th.

**COCAINE IN SURGERY.**—Speaking of the various uses of this late valuable addition to our materia medica, Dr. Samuel Logan, writing in the *New Orleans Med. and Surg. Jour.* for September, says, that in relieving the suffering due to painful defecation from any cause, much distress may be averted by means of the oleate, simply applied on a pledget of absorbent cotton as far into the anal orifice as the special case may demand. He has thus used it with marked satisfaction in cases of painful piles and fissures—that is, so far as the relief of pain is concerned.

In many of the important operations in rectal and anal surgery, he has strong hopes that its proper use will enable us to dispense, in a very great measure, with the use of general anaesthetics.

A short time since he operated by internal urethrotomy on three urethral strictures, very old, and recently causing much urethral and vesical trouble. He first thoroughly cocaineized the canal, by injecting into it three drachms of a four per cent. solution of cocaine, and after waiting fifteen minutes, throwing in an additional amount of water, and had the pleasure of seeing that his friend stood the cutting process with perfect indifference. He informed him that there was not the least pain, though the canal had been very sensitive to the passage of instruments.

It has been used in the operations of phimosis. It will answer better for the adult than for children, in this, as in many other operations.

In division of the contracted frenum a thorough application of the solution or the oleate on absorbent cotton, well pressed against each side, will be all that is necessary, while similar plans will answer for shipping off condylomata.

Preparatory to the cauterization for chancre and chancres, the local application of a four per cent. solution, or of the oleate, may be made by means of a dossil of absorbent cotton arranged to extend a little beyond the margin of the sore and well pressed into its surface, the latter having been gently dried. The cotton may then be covered with a fragment of surgeons' rubber tissue, and the whole bandaged snugly and kept thus dressed for about five minutes.

Turning our attention next to urethral troubles, we find the agent useful in facilitating our diagnosis, as well as aiding us in reducing the terrors of the surgical treatment. In exploring, with any kind of instrument, the urethral meatus and canal, and in entering the bladder for diagnostic purposes, by way of this canal, we often find ourselves giving great pain, and we also find that these are just the subjects most liable to urethral fever as a result of such explorations. This suffering can certainly be avoided or greatly mitigated by the use of cocaine. *M. d. and Surg. Reporter.*

**CONSUMPTION AND LIFE INSURANCE.** Dr. Davis, of Cincinnati, in the *Lancet* and *Clinic* of that city, tells us that notwithstanding the care exercised by examiners, that  $\frac{1}{8}$  of all deaths in the insured are from consumption, and that they live out less than one-fifth of their expectancy. As it is becoming better established that consumption is contagious, insurance companies will hereafter take measures to guard against applicants thus endangered. Sixty per cent. of all consumptives show heredity, direct or indirect. Mothers transmit the disease more frequently than fathers, at the rate of 135 to 100. Hence, if the applicant's mother were a con-

sumptive, he is a worse risk than *vice versa*. There exists a universal unwillingness to acknowledgment of consumption in the family. So when the applicant says his father died of "cold" or his mother of "debility," the examiner should suspect these terms to mean phthisis. Since consumption may exist that the most skilful investigator may not discover, consideration of the risk must be postponed should the applicant be suffering from the slightest cough, increased pulse rate or fever. Repeated disorders of digestion should engender suspicion, especially with any loss of weight. A rule among leading insurance companies is to reject an applicant who has had two near relations affected with consumption. The occupation must be carefully considered. The careful selection of lives by insurance companies have reduced their mortality to just one-half of that among the general population.—*St. Louis Med. & Surg. Journal.*

**THE USE OF IODOL IN SURGICAL OPERATIONS.**—Dr. Gatano Mazzoni calls attention to a new chemical preparation, called Iodol. The substance is a powder of a yellow or grayish-brown color, nearly odorless and perfectly tasteless, and has an action very similar to that of iodoform. The observations made upon its effects already exceed two hundred, and the results have been extremely favorable. The remedy may be used in powder, suspended in glycerine as an ointment, or in dilute solution of alcohol and glycerine, the substance being entirely insoluble in water. In venereal disease its effects have been excellent, as also in periadenitis. In abscesses, in which necrobiosis is extensive, the beneficial effect of iodol is manifested in the disappearance of all odor and the rapid disappearance of swelling and accompanying healthy granulations. In indolent ulcers a similar beneficial influence was noted. On the other hand, the remedy is found useless and indeed, harmful in gangrene. Further, it is found to possess the power in a high degree of prompting healthy granulations, as is shown by its use in various forms of lupus and in chronic fungoid inflammation of the joints. The chemical formula of the preparation is not announced in the article calling attention to its merits. *Berliner klin. Wochenschrift*, Oct. 26, 1885. *Med. News.*

**CEREBRAL SURGERY.** In the *Lancet*, May, 1885, p. 881, Dr. W. Macewen records the notes of a man aged 36, who, in August, 1883, fell down stairs, and was rendered unconscious for twelve hours. In November, 1883, the patient was admitted into the Glasgow Royal Infirmary, with impairment of power in the left arm, accompanied by muscular twitchings and pricking sensations in some parts. A lesion was diagnosed in the motor cortex of the right ascending frontal convolution, probably due

to irritation set up around an extravasation of blood due to the previous injury.

In December the author trephined, and found a membrane-like patch over the surface of the brain, involving the arachnoid and pia mater along with the external surface of the gray matter, there was also blood effused into the substance of the brain in the ascending frontal convolution. All this was removed, the bone was replaced, after having been broken up into several small pieces, and the wound was dressed with eucalyptus gauze. The patient made a perfect recovery without a bad symptom, and two months afterward was able to do his ordinary work.—*London Med. Record.*

**PARALDEHYDE IN PLACE OF CHLORAL.** A correspondent of the *Lancet* states he has used paraldehyde as a hypnotic in place of chloral, and prefers it to chloral for the following reasons:

1. There is no excitement preceding its hypnotic action.

2. It has no paralyzing effect on the heart.

3. It acts more quickly.

4. The sleep produced is more natural: it is dreamless and refreshing: the patient is easily aroused, and when left alone readily goes to sleep again.

5. There are no unpleasant symptoms: no confusion of ideas when the patient awakens; no head ache; no loss of appetite, even when the drug is long continued in large doses. The writer had used the drug about 150 times. The dose is from thirty to ninety minims, but the maximum dose is seldom needed to produce sleep. Smaller doses, repeated every hour, are preferable to large doses not so frequently repeated. *Chicago Med. Times.*

**PERIOSTITIS OF THE SPINE.**—Dr. Budd, *Brit. Med. Jour.*, reports the following case. R. M., a gentleman of active habits, had been affected for the last nine months with symptoms of periostitis. The spine and the bones of the pelvis were the parts chiefly affected. When he consulted me, there was much tenderness on the spinous processes of the third and fourth dorsal vertebrae, and also on the sternum. He had also suffered from severe pains in his limbs and trunk generally, which the least motion aggravated: coughing, sneezing, or laughing produced agonies of pain in the back and ribs. The pains were greater at night. A few days before applying to me, a new symptom came on. He became affected with sudden attacks of tetanic spasms, which fixed his limbs and extended his trunk, throwing his head back. It was a sudden shock, which relaxed again instantly. He found that the best way to avoid their recurrence was to lie on his back, and remain perfectly still. On enquiring into his past history, he told me he had had a sore on his penis seven years previously, accompanied by bubo, which was followed by nodes

on the shin-bone. He experienced salivation from the treatment pursued at that time. Feeling sure that his symptoms were a manifestation of the syphilitic virus, I ordered him a mixture containing five grains of iodide of potassium and five grains of Plummer's pill every night at bedtime. After taking these for a fortnight, he was greatly relieved in all his symptoms. The tetanic spasms had not returned since taking the medicine. A fortnight later, he was entirely relieved from his symptoms, and had gained strength and flesh. The next time I saw him, he expressed himself as perfectly cured.

**ENTERO-COLITIS.**—While the stools are yellow, homogeneous, and have a faecal odor, Dr. Louis Starr says alkalies and astringents are demanded, as.

R Sodii bicarb. . . . . gr. xxxvj.  
Syr. rhei. aromat. . . . . ʒ ss.  
Aq. menth. pip. q. s. ad . . . ʒ iij.

M. Sig.—One teaspoonful every three hours.

When the stools are green, acid, and numerous, alkalies with opium do best.

R Tinct. opii deod. . . . . ʒ vi.  
Bismuthi subcarb. . . . . gr. lxxij.  
Syrupi . . . . . ʒ ss.  
Mist. crete. q. s. ad . . . ʒ iij.

M. Sig.—One teaspoonful every two or three hours.

In tedious cases, good results are at times obtained from minute doses of calomel, combined with opium and chalk.

Very frequent and serious stools require more powerful astringents.

R Acidi sulphurici aromat. . . ʒ xxiv.  
Liquor Morphie sulphatis . . ʒ j.  
Elix. curacoæ . . . . . ʒ ij.  
Aquam q. s. ad . . . . . ʒ iij.

M. Sig.—One teaspoonful every three hours.

*Med. Bulletin, Aug*

**PNEUMONIA. HYPODERMIC INJECTIONS OF ETHER.**—In adynamic pneumonia when there is considerable depression of strength and the ordinary means have been exhausted, while the patient is incumbered by asphyxia, Dr. Barth injects hypodermically a Pravaz syringe-ful of sulphuric ether, repeating it a second, third, or even a fourth time in the day in bad cases. These injections render the cough easy and allow the bronchi to clear themselves. They may be inserted at the external side of the thighs, the back, or sides; and they give rise to a sharp burning sensation, which, however, soon subsides. Dr. Féréol employs these injections whenever he has to do with excessive debility consequent on hemorrhage, typhoid fever, etc. He regards them as a valuable means of restoring life to patients who are exhausted and threatened with speedy death. Dr. Moutard-Martin has used

them with success in the algidity and cramps of cholera. —(*Union Médicale*) *London Med. Times*, Aug. 8th.

**OPERATION FOR EXTENSIVE LOSS OF SKIN IN THE ARM, JOSEPH BELL.**—In 1883, N. L., during a very severe attack of phlegmonous erysipelas, lost the greater part of the skin of the inside of his right arm, from the posterior fold of the axilla down to within three inches of the wrist-joint. He came under my care with the view of having an amputation performed at or near the shoulder-joint. After months of treatment, however, by skin grafting, rest, etc., cicatrization had progressed, till only a wound about  $3\frac{1}{2}$  inches long by 1 broad remained inside of elbow-joint. This refused to heal any further, a dense cicatrix ringed in the arm for about three inches of its length, and the tissues around were constantly reopening. He again was admitted in June, 1885, requesting amputation. I thought it a pity to sacrifice a good hand, so determined to shorten the limb. This I did by cutting down upon the humerus three inches above the elbow-joint behind, and removing subperiosteally the whole lower three inches, including the condyles and cartilage, and also the olecranon. He has now a useful arm with full flexion, extension, pronation, and supination, shortened barely two inches, and healed.—*Edinburgh Medical Journal*, Sept.

**A STRONG ARGUMENT IN FAVOR OF VACCINATION.**—Among the many queries which the present extensive revival of vaccination has raised, is the one relating to the effect of vaccination upon one who has already had small-pox or varioloid. We have been somewhat surprised to find that vaccination "takes" with those who have had small-pox, two or three such cases having come under notice. Upon inquiring of a physician, whose position at the Board of Health has given him a wide opportunity for observation, he assured us without hesitation that after small-pox vaccination will take always, and in the primary form. Moreover, that vaccination is a surer safeguard from small-pox than small-pox itself, for he knew of instances where unvaccinated individuals had had the disease two or three times. This information is therefore of great importance, for most people who have had small-pox, feel that they are sealed with an immunity greater than a life-time of continued vaccination could purchase for them. *Med. Record*.

**THE TREATMENT OF NIGHT SWEATS.**—I send herewith a prescription for night sweats, which I have used for many years and found to be very efficient. It is very rare that more than three pills in the twenty-four hours are necessary to promptly stop the trouble; and, notwithstanding the fact

that these pills are directed only for the relief of a disagreeable symptom, many patients suffering from phthisis declare that they are of real benefit in aiding a case of the disease, and continue to persist in their use long after night sweats have ceased.

This prescription I have found very efficient, also, in relieving the nervous prostration that is so often seen in those who drink alcoholic liquors to excess:

R.—Oxide of zinc, . . . . .	gr. 12
Pyrogallie acid, . . . . .	gr. 24
Sulphate of atropia, . . . . .	gr. 1-24
Extract of lupulin, . . . . .	gr. 48

Mix.—Make 24 pills and silver coat.—Dose, one pill three times a day, soon after meals.

—Dr. Smith, in *Gaillard's Medical Journal*.

**STYPTIC OR HEMOSTATIC ETHER.**—Dr. B. Ward Richardson gives us an ether which, while checking hemorrhage by cold, overcomes the subsequent relaxation of the vessels by its constringing action. He has had prepared a solution of absolute ether, having a boiling point of 95° Fah., charged to saturation at a low temperature with tannin, and afterwards treated with collodion, a little short of saturation. The compound ran easily through the spray tube without blocking; it produced good local anæsthesia, and it possessed an agreeable odor. He tested it in a few drachms of blood which had been deprived of its fibrin by whipping, and then left for two days exposed to the air until it underwent partial decomposition. The blood was placed in a saucer at the temperature of the body, the spray made to play upon it, and in five seconds the whole mass of blood was so thoroughly solidified that the saucer could be turned upside down without any escape of fluid. The blood was also deodorized, and remained inodorless for ten days.

When styptic spray is directed on an open bleeding, living surface, the primary effects are those produced by the cold—namely, the condensation and whitening of the tissues. If blood be flowing, it solidifies, and when the parts relax, new blood that may ooze up enters the solid blood as though it were a sponge, the coagulation soon stopping further flow.

The elements of this process are three in number:

1. The immediate constringent effects of cold on the blood-vessels.
2. The styptic action of the solution on the fibrin and albumen of the blood.
3. The extreme mechanical fineness of distribution of the fluid on the bleeding surface.

Styptic ether can also be applied to the hemorrhagic surface after the extraction of a tooth, for hemorrhage from cancerous disease of the uterus or other cause; and in cases of hemorrhage from piles.—*The Asclepiad*, July, 1885.

**GALVANO-PUNCTURE IN PELVIC HEMATOCELE.**—M. Apostoli strongly recommends the use of the galvano-puncture in peri-uterine hematocle (*Lancet*). The instrument he uses is a trocar of medium size connected with the negative pole of a battery, the other electrode being of considerable size and applied to the back or thigh. Care must, of course, be taken to avoid wounding the uterus, intestine, or any important blood vessel. A large dose, even as much as 100 milliampères, should be given, the resulting slough and fistula being proportioned to the current employed. As to the duration of the galvano-puncture, five or six minutes is usually sufficient, but should be regulated by the loss of substance and chemical action which it seems desirable to produce. M. Apostoli thinks that all peri-uterine hematoceles should be treated in this way, and that the earlier the operation is performed the better. Antisepsis should be carried out as far as possible, first by heating the trocar prior to puncturing, and afterwards by carbolic acid injections into the sac twice a day. —*Medical Review*.

**BELLADONNA AND IODIDE OF POTASSIUM.** The fact that belladonna produces dryness of the throat, nose and mouth has induced Dr. Anbut to try it rather empirically to combat certain disagreeable effects of iodide of potash, and he has published his results in the *Lyon Medical*. In three cases of naso-pharyngeal intolerance of the iodide, a mixture of belladonna with iodide of potassium has given good results. He had also the same success in a young man suffering from acute iodism, in whom he made this symptom disappear by preceding the administration of iodide of potassium by the extract of belladonna. The dose was two pills of five centigrams each, of the extract per day, one in the morning and the other at night. In one of the cases he was able to suspend the use of belladonna after some days, continuing the administration of iodide of potassium alone, without producing any intolerance. —*Cin. Lancet and Clinic*.

**HYPODERMIC USE OF OILS.**—In cases of obstinate constipation, Dr. J. V. Shoemaker frequently uses castor oil hypodermically. A drachm or two of castor-oil, mixed with an equal quantity of oil of sweet almonds, in order to obtain the required fluidity, is injected, and produces a satisfactory evacuation in about an hour. But the most useful application of oil hypodermically is in diseases of the digestive organs, when nourishment cannot be taken in the natural way, and in tuberculosis, scrofula, and all forms of defective nutrition cod-liver or olive oil should be used in doses of about two drachms, two or three times a day. The nutrition and general tone of the system will improve wonderfully. When the oil is given every two hours it will sustain the system without other

food. The treatment of many obstinate skin affections is greatly aided by the hypodermic use of cod-liver oil. No abscesses follow the injections. A large hypodermic syringe, with a capacity of from two to eight drachms should be used, and portions of the body well supplied with cellular tissue, as the superior and inferior scapular and sacral regions, should be selected. Injections can also be made in the arms, thighs, back, or abdomen. Doses of one-half ounce have been administered without causing inflammation of the skin or producing any unfavorable effects. —*Med. World*, Sept.

**SUSPENSION OF THE CARBOLIC SPRAY IN GENERAL SURGERY.**—Professor Chiene, the pillar of the carbolic "spray" system among Edinburgh surgeons, has formally announced his intention of tentatively relinquishing the use of that instrument in his wards in the Royal Infirmary, for a term of six months. Irrigation with corrosive sublimate solution is to replace the older method. Many reasons have doubtless led to the abandonment of Mr. Chiene's long-prized vantage ground, but that which appears most present to the mind of this distinguished teacher of surgery is the curious fact that, though in season and out of season he has been the bold apostle of the spray, comparatively few of his students have seen their way to adopt it in the practice of their profession outside the hospital walls. This admission suggests interesting and curious comment, both on the quality of the seed and the character of the ground on which it has been sown, but from this we forbear. Edinburgh graduates are not likely to allow that the sower is to blame. —*Cin. Lancet and Gazette*.

**ACUTE CORYZA.**—Dr. S. S. Cohen recommends, as a specific against acute coryza, the 1-120th of a grain of atropia, to be repeated every four hours until there is dryness of the throat. He says that this remedy will cure nine out of ten cases of coryza if taken at the incipency of the disease. Afterwards to relieve the unpleasant symptoms of dryness he has given 1-16th of a grain of pilocarpine with good results. When cases are seen too late to use atropine with advantage, he has obtained good results from ammonium salicylate in doses of ten to fifteen grains repeated every two hours until *tininitus aurium* is produced. If the patient does not object to the expense, cocaine can be used to allay the local symptoms until the medicine has had time to act. —*Phila. Med. Times*, Aug. 8th.

**CHRONIC DIARRHŒA.**—In the *Brit. Med. Journal* August 22, Dr. J. Vose Solomen says that he is sometimes consulted by females of nervous temperament, on account of chronic diarrhœa, of



several years' standing, and which has hitherto resisted medical treatment. As many as six or eight stools have been reported as passed daily. When failing to discover organic abdominal disease, the following formula has produced considerable mitigation, and sometimes a perfect relief to the symptoms. He is inclined to think the disorder is a neurosis:

R. Acidi nitrici diluti,	ss.
Liquoris opii sedativi (Battley),	3j.
Tincture gentianæ,	5ss.
Infusi gentianæ,	3ivss.
Aquam menthæ piperitæ fort. ad.,	3viij.

One ounce to be taken three times a day.

*Med. and Surg. Reporter.*

**PERFORATING ULCER OF THE HAND.**—At a recent meeting of the Surgical Society of Paris, M. Terrillon (*Revue Médicale*, June 13, 1885), presented a patient, aged twenty-six, who had on both hands ulcerations surrounded with thickened epidermis resembling exactly perforating ulcer of the foot. The lesions were surrounded with an anæsthetic zone. There could be no doubt of their origin from a central nervous lesion, and the patient also had other symptoms pointing unmistakably to locomotor ataxia. M. Terrillon had also presented a similar case at a previous meeting. M. Trélat recalled an observation previously made by him, of the relation between perforating ulcer and central nervous lesion, and stated that he had seen the ulcers upon both hands and feet in the same subject who was ataxic.—*N. Y. Med. Record*, Aug. 15th.

**CUTANEOUS ANODYNE.**—Dr. R. G. Couch, of Richmond, Va., recommends the following prescription as one of the best he has ever found as a lotion for itching cutaneous surfaces, whether the skin is broken or not. He has used it with invariable success, and it has now become a popular application with the people as well as the doctors of this city:

R. Sodæ biborat.	3j
Acid. carbol.	gtt. xv
Glycerin	3j.—M.

Sig. Apply as lotion with camel's-hair brush, or by dropping from bottle on the itching surfaces. *Virginia Med. Monthly*.

**LEMONS IN BRIGHT'S DISEASE.** Before the Medical Society of Otsego County, this subject was discussed. It was shown that patients who have the symptoms of the disease strongly marked, not only in many instances live for a long time, but make an apparent recovery. Dr. H. W. Brown cited the case of a man who had, as he thought, all symptoms of the disease last autumn, his urine under heat showing that it consisted almost wholly

of albumen. This patient having a desire to eat lemons, began eating them to an extravagant extent, eating as many as six or eight a day. At the present time he is about his business as a small peddler, and his urine examined this day shows no albumen whatever. *Medical and Surgical Reporter.*

**TREATMENT OF ERYSIPELAS.**—Prof. Da Costa gave the following modes of treatment in *erysipelas*, and said: To modify a case there are several plans of treatment, to wit: 1. The old, but still useful method of purging by diaphoretics and diuretics. 2. Quinine, grs. xii-xvi. in twenty-four hours, is of much value. 3. Tr. ferri chloridi, in large doses, ℥xx, every three or four hours. This is an admirable plan. 4. Pilocarpine—inject gr.  $\frac{1}{6}$ – $\frac{1}{4}$  under skin—great success followed the use of this remedy in several cases in which it was tried during the session. The fluid extract of jaborandi may be used when pilocarpine cannot be obtained. In the cases with delirium, stimulate freely.—*Col. and Clin. Record.*

**A NEW HEMOSTATIC AGENT.**—Dr. Spaak (*Journ. Med. de Bruxelles*), claims for the following simple solution, excellent, not to say fabulous results. Chloroform, 2 parts, water, 100 parts. He says that he has used this hæmostatic liquid for several months and attributes to it the following great advantages: 1. It acts with truly wonderful rapidity. 2. It possesses no escharotic action. 3. It is to be had everywhere, and may be prepared instantaneously. 4. It costs very little. 5. It possesses no disagreeable effects, and does not hinder a surgeon in his operations.

**PROF. LASKOWSKI**, of the University of Geneva, who is probably the most successful embalmer in Europe, is reported in the *Lancet* to use an injecting liquid consisting of a mixture of carbolic acid, chloride of zinc, and corrosive sublimate, with the addition of an odoriferous essence. This solution is as clear as crystal, and pleasant to smell. A body skillfully treated by Dr. Laskowski's method assumes "the natural and agreeable expression" it bore immediately after death, and the skin becomes firm and as white as Carrara marble.—*Boston Med. and Surg. Journal.*

**HOW TO BLISTER QUICKLY.**—Put a few drops of the concentrated water of ammonia (aqua ammoniæ fort.) in a watch-glass, butter-dish, shallow cup, or other article of like nature, and cover with a pledget of cotton. This inverted and pressed closely to the spot to be blistered, will accomplish this object in from 30 to 60 seconds. It should afterwards be treated as if produced by cantharides.—*Southern Clinic.*

# THE CANADA LANCET.

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## ALCOHOL AS MEDICINE.

Alcohol, although the first and oldest of all medicinal agents, and, in some respects, best known, is still an enigma in the science of therapeutics. While other powerful narcotics, stimulant and sedative, have been assigned their places with some degree of definiteness, alcohol may be compared to a weathercock, ever changing its position according to the "wind of doctrine," which, for the time, blows hardest. This is chiefly to be accounted for by the many-sidedness of this agent. In its case it is difficult to dissociate therapeutics and morals. Contemplating the horrible evils consequent upon the excessive use of alcoholic stimulants as a beverage, the moralist, though a physician, may easily come to regard alcohol as only an evil, and that "continually." On the other hand, the physician who, viewing the subject from a totally different standpoint, may, as easily, come to regard it as of universal benefit, both in health and disease. And, thus it comes to pass that, as relates to this agent, the medical profession is divided into three distinct parties. At one of the poles we find the doctor of "many drams but few scruples": at the other end the doctor of many scruples but no drams: and, between the two, the doctor of the golden mean, who, while deploring the evils of intemperance, still proclaims his belief in alcohol as a remedial agent.

The history of alcohol shows it to have been at all times intimately interwoven with the life of

mankind, as drink and medicine. At all times, but more especially in modern times, it has entered largely into the social life of civilized nations. It should never be forgotten that alcohol is not an un-mixed good, but alas! a great evil. Hence, at the very threshold of our enquiries regarding it as a therapeutic agent, we are beset with many difficulties. Some use it habitually in moderation, some to excess, and some do not use it at all. Uniformity of dose and action under these varied conditions is manifestly out of the question. The moral aspect of the question, also, at once suggests itself. The life lying before is no less important than the present. In seeking to overcome a present evil we must endeavor not to burden the future with a greater evil. Alcohol is like a two-edged sword: it can cut both ways. A weapon so sharp and powerful needs cautious and skilful handling. Another difficulty encountered, is the number of combinations in which alcohol is presented to us for medicinal use. We have wines, malt liquors, and ardent spirits in endless variety, all differing in strength, not merely as relates to separate classes, but the varieties composing each class as well. This fact suggests two questions. First, the place of each in disease: and, secondly, the dose. Manifestly, the answer can be but little better than a guess. This remark receives additional force from the fact that we cannot know the strength of the article prescribed. Originally varying and uncertain, modern devices have made it still more an uncertain quantity.

No question in therapeutics is so hampered by the influences of habit and prejudice. In considering the place of alcohol it is hard for the average physician to divest himself of all preconceived notions and opinions, and to conduct his investigations with strict impartiality. The abstract scientist may, but the average doctor shares largely the frailties, habits, and prejudices common to other men. The "brandy" doctor was more a character of the past than the present. Still, he is with us. He is not open to conviction. He is impatient of argument, and dogmatic in belief. He formed his opinions long since, and is not to be driven about by newfangled ideas, started by diving chemists and over-zealous moralists. He is thoroughly convinced of the universal healing properties of brandy, and by it he will stand or fall. All thinking men will admit that the presence of such a person is a

potent factor in the promotion of drunkenness. In like manner may be traced the history and mental bias of the physician who denies altogether the benefits usually ascribed to alcohol. His opinions will generally be found based on sentiment rather than accurate scientific investigation. He is more inclined to bend science to his opinions than his opinions to science. The opponents of alcohol as a therapeutic agent are not, however, without benefit to society. They present the question in striking contrast, and so aid in impressing society with the evils of excessive drinking.

It is scarcely necessary to argue with either of the extremists in this controversy. Still, an occasional review of this question is essential to watchfulness and the avoidance of extremes. We cannot escape the frequent consideration of an agent so powerful for good and evil, filling so large a space, not only as a medicine, but also as a beverage. According to the present state of knowledge, supported by the daily experience of thousands of acute observers, there can be no doubt of the value of alcohol in certain diseased conditions. True, the range of application is not nearly so wide as formerly believed, and yet believed by many who refuse to read the evidence. Yet, within certain limitations, alcohol has undoubted benefits.

We have long felt the necessity for a radical change in the mode of administering alcohol. It is, therefore, with pleasure that we recently noticed expressions in different influential quarters, in support of such a view. The first objection to any, and all the standard combinations is, that they are most likely known to the patient, and it may be to the use of which he is, or has been addicted. To give such a patient his old favorite drink, would be, almost infallibly, to fire up the old appetite. But there is also a scientific reason for such a change. We do not generally prescribe wine, beer, whiskey or brandy, as such. It is the alcohol we are after, and hence select the menstruum much as we wish a slight, for more powerful stimulant, determined also, not unfrequently, by the taste of the patient, to which, as already stated, it may not be prudent to cater. As a matter of fact we cannot, even approximately, regulate the degree of stimulation desired by any of the common liquors, owing to the want of uniformity in the quantity of alcohol contained. These and other facts which might be named, are cogent arguments in favor of the use of

simple alcohol, diluted and disguised according to taste and fancy. In this way we can prescribe this agent with the same definiteness of dose as opium or any other medicine. Dr. Norman Kerr, of London, Eng., tells us that he has followed this method for over twenty-five years. His favorite combination is, compound tincture of cardamom, aromatic spirit of ammonia, with a little of the spirit of chloroform. This combination may be varied both by addition and subtraction, as circumstances require. This mode of prescribing alcohol has the additional recommendation of cheapness, a no small consideration in many cases. The annual liquor bill of hospitals and other charitable institutions would be greatly reduced by the adoption of this method, against which there can be no scientific or other valid objection.

### TRAINED NURSES.

In an article in a recent number of the *Louisville Medical News*, the writer alludes to the importance and value of thoroughly trained nurses in the sick room. The writer also refers to the workings of the training schools for nurses attached to the New York Hospitals, and the rapid progress made by them since their foundation eight years ago. He also shows that since their establishment the death rate in the hospitals has fallen very considerably. At Charity Hospital on Blackwell's Island, the first year after their inauguration, the death-rate fell thirty per cent. "The proper place for the education of nurses is undoubtedly in the wards of our hospitals. Here they are brought in contact with all kinds of disease, and here they can obtain such knowledge as is necessary to the proper performance of their functions in the sick-room. They should receive rudimentary instruction in anatomy, physiology, hygiene and preventive medicine, and it would perhaps be wise to teach them the doses of drugs, their physiological and toxicological effects, and the antidotes for poisons. The application of the bandage and the uses of the thermometer and catheter are necessary accomplishments. By some one trained in the art of cooking, they should be taught to prepare the articles of diet required by the sick. To acquire this knowledge is needed only close observation, quick perception, and a sufficient amount of practical every-day experience."

The physician in charge of a serious case of ill-

ness should always have some one in constant attendance who can become responsible for the care of the patient during his absence, and to whom he can give the proper directions, feeling sure that they will be carried out to the letter. It is evident that a member of the family is not the proper person for such a trust; since anxiety, timidity, and the entreaties of the patient may warp the judgment. The value of a well-trained nurse can not be overestimated, being second only to that of the physician. A circumstance is related as having occurred in one of the New York hospitals, which goes far to prove this assertion. A patient operated upon soon after began to bleed from one of the larger vessels in the neck. In a few seconds, even before the house surgeon could have reached him, he would have been dead. With rare presence of mind, the nurse thrust her fingers into the wound, compressed the bleeding vessel, and saved the patient's life. Of course, none but a person trained for such emergencies would have thought of this.

Besides providing for the public poor, efficient nurses, and for the community the opportunity of obtaining competent help in the sick-room, the scheme opens an honorable and most useful avocation for woman, and one that in time will become remunerative to those who pursue it. That it is considered respectable is shown by the fact that there has been no lack of applicants for the position from among all classes of the community. The calling should, and will rank as a profession second only to that of the physician.

Much good work in this relation has already been done in our own hospital in this city. Well trained nurses are being provided as rapidly as the opportunities will permit, so that physicians can be supplied almost at a moment's notice with a trained nurse competent to undertake any case either medical or surgical. This is a most gratifying circumstance to the profession, and one for which they have to thank the worthy Medical Superintendent and Trustees of the Toronto General Hospital, and those who have aided in the instruction and qualification of the nurses.

#### ANNUAL MEDICAL BANQUETS.

The annual banquets of the students of the medical schools of this city were held on the evenings of the 24th and 26th ult., respectively. The din-

ner of the students of the Toronto School of Medicine was the first to take place and was largely attended. The chair was occupied by Mr. Peaker. In his opening address he alluded to the success of the school and the high standing the students had taken both at home and abroad, and stated that there were 225 students enrolled on the books. He then proposed the toast of "The Queen," which was duly honored. The toast of the "Universities and Colleges" was responded to by Rev. Dr. Castle of McMaster Hall, Rev. Father Teefy of St. Michael's, and Mr. Baker of University College.

Dr. Castle insisted upon the importance of broad and generous scholarship as opposed to one-sided education. The universities and colleges were conservators of education. The noblest adornment of any country was its wealth of education. The most material wealth was what appeared most immaterial. The best preparation for any profession was a thorough training given in the arts course. If there was any danger, it was that of turning the arts courses into semi-professional, under the plea that they are the honour courses. The honour ought to be for excellence in all the courses. Rev. Father Teefy said that the students should think first of their country and next of their university. He spoke of the necessity of wise and prudent words and moderate councils, especially in great cities. Mr. Baker said he hoped the recent changes in the regulations for matriculation would increase the number of medical students of the University.

The Mayor responded for the city, and said he was happy to be able to express his opinion that the students had nothing to do with the recent outrage.

"The Sister Institutions" was responded to by Dr. Fulton and Mr. McEdward for Trinity, Mr. Worthington for McGill, Mr. Cregan for the Royal, of Kingston, and Mr. Balfour for the Western, of London. Dr. Fulton's theme was the necessity for a uniform standard of matriculation: there were too many varying standards. He congratulated the students on the excellent opportunity which the hospital afforded for clinical instruction.

"Our Faculty" was responded to by Drs. Richardson and Graham. Dr. Richardson pleaded for State aid in the study of the organisms to which

so many diseases have been traced. The French Government gave great aid to Pasteur in his researches. In the matter of vaccine virus, Canadian doctors had to depend upon the United States for their supply. Dr. Graham's topic was the kindred one of private aid and the endowment of medical schools.

Mr. Eadie, one of the Vice-Chairmen, proposed "The graduates and the graduating class," and elicited speeches from Dr. Pickard and Mr. W. C. Heggie.

"The Hospital" was responded to by Dr. O'Reilly; "Sister Professions," by Mr. W. F. Maclean, and Mr. Lockie; "The Freshmen," by Mr. Geo. Watson. The toast of "The Ladies" was duly honoured, and the gathering dispersed. Songs by the students varied and enlivened the proceedings.

The annual banquet of the Trinity Medical School surpassed in every respect, the eight preceding annual gatherings of a similar nature, that have marked the progressive career of this institution. Between two and three hundred professors, students, and guests were present. At the head of the dining hall which was gaily decorated with flags and banners, were suspended the portraits of Dr. Rolph, "the father of medical education in Canada," and Dr. Hodder, the first dean of Trinity Medical School.

Mr. Lapp, a fourth year student, presided. After doing justice to the good things provided, toast, song, and sentiment became the order of the evening. After the usual loyal toasts, came the toast of the Dominion and Local Legislature, coupled with the names of Hon. T. W. Anglin, and H. E. Clarke, M. P. P. The latter made a humorous semi-political speech in opposition to the present Ontario Government, for which he was taken to task by the Hon. Mr. Anglin, who said that the Government had shown its wisdom in keeping Mr. Clarke's party in the position they now occupied.

The "Army and Navy" was responded to by Lieut.-Cols. Otter and Grasset.

The Mayor in responding to the "Mayor and Corporation," assured the students, to their evident gratification, that so long as they did not carry their pranks too far, he would "stand by them." It was evident, he said, from the fact that

the toasts were being honored in water instead of wine, that the students were aware of the successful efforts that had been made to give the citizens pure lake water.

His Grace, Archbishop Lynch, responded to the "Learned Professions." His Grace expressed pleasure at being present and said the medical profession was the most important of the learned professions. He would like to put his own first because they took care of the souls, but a soul was a very poor thing without a body. Physicians were called upon for more acts of charity than the members of any other profession. He thanked them and wished them every prosperity in their profession. Dr. McMichael, Mr. Osler, and Dr. Canniff also responded to this toast.

"Universities with which we are affiliated and Sister Institutions" was coupled with the names of Prof. Clark, Trinity College; Rev. D. J. Macdonnell, on behalf of Queen's University; Mr. J. J. Maclaren, Q.C., on behalf of Victoria College; Dr. Richardson and Dr. Graham, of Toronto School of Medicine; Mr. Jones, representing the students of the same school; Mr. McGannon, of McGill Medical School; Mr. Dixon, Kingston Medical School, and Mr. Wilson, London Medical School.

Dr. Geikie, in reply to the toast of "Trinity Medical School, its graduates and under-graduates," referred to the speech of Hon. Edward Blake in Scotland, reported a few days ago, in which the Chancellor of the Toronto University had referred to the great progress being made in Canada. If such matters as Mr. Blake referred to could be pointed out with pride by every true Canadian, the great progress made in medical education in this country could also be pointed to with pride. He also referred to the great advances in this branch made in Canada during the past twenty-five years.

Dr. Stark, of Hamilton, responded to the toast in behalf of the graduates, and Mr. Honsberger in behalf of the under-graduates.

Dr. O'Reilly responded to the toast of the "Toronto General Hospital;" Dr. Fulton, for the "Press," and Dr. Bingham for the "Ladies." Some excellent songs were rendered by the students during the evening.

**ONTARIO MEDICAL ACT AMENDMENTS.**—A meeting of the profession in the territorial division of Midland and York, was held in Toronto on the 16th ult., to consider the proposed amendments to the Ontario Medical Act and to frame a tariff for the division. The following amendments were agreed upon: 1st. That colleges and universities that neither teach nor confer degrees in medicine, shall not be entitled to representation on the council. 2nd. That all actions brought against medical men for malpractice must be instituted within one year from the date of such alleged malpractice. 3rd. That the clauses in the British Medical and Dental Acts, relating to the power of suspending or erasing the names of licentiates from the register, guilty of infamous or disgraceful conduct from a professional point of view, be incorporated in the proposed measure. The remaining clauses relating to the question of security for costs in suits for damages, the proper payment of medical witnesses, and the appointment of a taxing officer, were, on the recommendation of the Solicitor, passed over. The consideration of the tariff was postponed for future consideration.

**ROGERS' GROUPS OF STATUARY.** The latest accession to these celebrated groups by this well-known artist is shown in the cut, and is entitled "King Lear and Cordelia." It is taken from Shakespeare, and represents a scene in King Lear. The king has banished his daughter Cordelia and divided his kingdom between his other two daughters, but their ingratitude and ill-treatment have driven him crazy. He is represented on a couch, and behind him stands his old friend Kent, disguised as a servant, and the doctor. His daughter Cordelia, who loves him dearly in spite of his former harsh treatment, tries to recall herself to his wandering mind. We need not say that the group is in the artist's best style of art and must be seen to be fully appreciated. This, or indeed any of the groups in the catalogue would be a most suitable Christmas or wedding present. See cut of "King Lear and Cordelia," among the advertising pages.

**LACTIC ACID IN TUBERCULAR LARYNGITIS.**—The application of a ten per cent. solution of lactic acid to the ulceration and swelling of the larynx caused by tuberculous deposit has been at-

tended with very beneficial results at the hands of physicians in Germany and elsewhere. The strength of the solution may be gradually increased to eighty per cent. A number of cases are reported in which the ulceration was completely cured by these applications, notwithstanding the presence of tubercle-bacilli. In view of the unfavorable course which such cases generally pursue and the failure of all other treatment, this is a decided step in advance. Lactic acid may also be found useful in other disorders of the throat.

**BILLROTH'S VIEWS ON ANTISEPTICS.** Billroth writes the following on antiseptics: 1. Iodoform is the safest and most effective of all manageable antiseptics. 2. Moss, wool, turf, mould, and oak-um are useful when there are discharges from the wound. 3. Corrosive sublimate in dilute solution is practically inert as an antiseptic to wounds, and renders the patient and surgeon alike liable to mercurial poisoning. 4. Carbolic acid, which is known to be dangerous in strong solutions, is, in very weak ones, as good for wound irrigation as clean water, but probably no better.

**WARBURG'S TINCTURE.** The following is said to be Dr. Warburg's own formula, first published in 1875:

R. Socotrine aloes.....	lb. 1
Rhubarb (East Indian)....	oz. 4
Angelica seed.....	" 4
Confect. of damocratis ..	" 4
Saffron.....	" 2
Fennel seed.....	" 2
Prepared chalk.....	" 2
Gentian.....	" 1
Zedoaria.....	" 1
Cubebs.....	" 1
Myrrh.....	" 1
Camphor.....	" 1
White agaric.....	" 1

#### Mix.

These ingredients are to be digested with 500 ounces of proof spirit in a water-bath for twelve hours, then expressed, and ten ounces of quinine sulphate added, the mixture to be replaced in the water-bath till all the quinine is dissolved. The liquor when cool is to be filtered, and is then fit for use.

**THE CALOMEL TREATMENT OF PNEUMONIA.** There have appeared of late many favorable reports regarding the treatment of pneumonia by

the use of calomel in fractional doses. The usual dose advised is from one-fifteenth to one-twentieth of a grain every hour. We think there is no doubt as to the good effect of calomel in cases of high temperature, dry tongue, hot, dry surface and delirium. When continued in these cases for forty-eight hours or less, the tongue usually becomes moist, the skin damp, the depression is markedly less, and the temperature is lowered.

**INOCULATION FOR HYDROPHOBIA.**—It is said to be a settled fact that inoculation is a safe preventive of hydrophobia. If it be true, M. Pasteur, who produced the attenuated rabic virus, is justly entitled to all the credit. Pasteurs' inoculations can be applied to all the dogs allowed to live, and hence there would be little danger of the human being. When this inoculation has been demonstrated to be a sure preventive, laws, such as are now in force regarding bovine-virus vaccination in the human subject, will be enacted, requiring the inoculation of dogs and other animals.

**MCGILL MEDICAL COLLEGE—NEW WING.** The opening of the new wing of McGill Medical College took place on the 22nd of October, and was a most successful affair. Prof. Pepper, of Philadelphia, delivered an able and eloquent address on the occasion. He dwelt on the benefits of higher medical education, and the more complete endorsement of the better class of medical schools. Prof. Osler also gave a short address, which was enthusiastically received by his old students. A grand banquet was given by the Faculty in the evening at the Windsor Hotel. A description of the new wing appeared in our advertising pages in the August and September numbers.

**CARBOLATE OF IODINE INHALANT.** The following is said to be similar to Cutler's:

R	Tinct. iodini co. . . .	minims 180
	Acid, carbolic, No. 1 . . .	" 48
	Glycerin . . . . .	fl. dr. 1
	Water . . . . .	fl. dr. 5

Mix and expose to the sunlight until the mixture is entirely colorless.

The proportion of carbolic acid and tincture of iodine may be largely increased without a corresponding addition of glycerine.

**ERGOT FOR HICCUGH.**—A correspondent in the

*Lancet* calls attention to a new use for an old remedy. A policeman had hiccough which resisted all the ordinary means of relief, and he was passing into collapse, when drachm doses of liquid extract of ergot were ordered, with complete relief. Only three or four doses were required. After a period of rest the hiccough returned, but was again stopped by the ergot, and did not re-appear.

**VINEGAR IN DIABETES.**—A correspondent in the *Physician and Surgeon*, has recently used vinegar successfully in the treatment of diabetes. The patient was put upon anti-diabetic diet, and one-third of a glass of vinegar diluted with water was given daily. The urine was free of sugar within a week. At the end of two months' time there was no return of the disease.

**ADMINISTRATION OF IODINE AND ITS SALTS.**—In prescribing iodine and its salts it should always be borne in mind that they are to be administered on an empty stomach, as the presence of starch and acids modifying or decomposing the preparations of iodine would reduce or prevent their effect. This is not generally known or observed, but is an important fact which should not be lost sight of.

**APPOINTMENTS.** Dr. W. G. Johnston has been appointed pathologist to the Montreal General Hospital; Dr. J. B. Saunders has been appointed Prof. of Botany in Bishop's Medical College, Montreal; Dr. McNeece has been appointed assistant medical health officer for Montreal; Dr. J. J. Gardner has been appointed physician to the Protestant small-pox hospital in Montreal.

**TORONTO UNIVERSITY EXAMINERS.**—The following gentlemen have been appointed examiners in this university, on the following subjects:—Dr. Geo. A. Tye, of Chatham, Physiology and Histology; Dr. D. B. Fraser, of Stratford, Anatomy; Drs. Graham and Grasett, Toronto, Clinical Medicine, and Surgery, respectively. The remaining examiners are the same as last year.

**COCAINE IN FISSURED NIPPLES.**—This remedy so useful in a variety of cases has been found of great service in this painful affection. The four per cent. solution is applied with a camel's hair pencil. Anaesthesia is produced in about five minutes, and the child may be permitted to nurse without pain or distress to the mother.



**VALUE OF EUCALYPTUS.**—A writer in *Pacific Med. and Surg. Journal* says of the effects of the fluid extract of eucalyptus globulus, after an experience of eight months in its use in the Marine Hospital, that he regards it as a diuretic of rare virtue, capable of being administered when other diuretics in common use are inadmissible. It is an aromatic tonic, and has notable restorative effects in low states of the system, as typhoid fever, typhoid diarrhoea, and dysentery. In vesical catarrh its action is very valuable. As an external application in chronic ulcers it has great value.

**SOLUTION OF BROMIDE OF ARSENIC.** The following is known as Gillford's solution of bromide of arsenic so highly spoken of in the treatment of diabetes mellitus, epilepsy, etc.:

R. Acid. arsenios  
Pot carb. . . . . *aa* . . . . 5j  
Bromine . . . . . . . . . . ʒij  
Aque . . . . . *ad* . . . . 3xx M.

The arsenious acid and potassium carbonate are dissolved in four ounces of water by the aid of heat, and when cold, the solution is made up to twenty ounces and the bromine is then added. The dose is from ten to twelve drops after each meal.

**DIPHTHERITIC SORE THROAT.**—The following has been found a useful application for the relief of diphtheritic sore throat:

R. Tr. iodinii.  
Tr. ferri sesquichloridi. . . . . *aa* 5j  
Glycerini . . . . . 5 ss. M.

**SIG.**—Apply with a camel's hair pencil four or five times a day.

**REMOVALS.**—Dr. N. A. Powell, of Edgar, Ont., will remove into this city on or about the first of January, 1886. Drs. Pattullo, of Brampton, McMahon, of Fergus, and Ghent, of Priceville, have recently removed to this city. We heartily welcome these gentlemen to the great metropolis.

**PELVIC ANODYNES.**—Dr. Alfred Meadows (*British Medical Journal*): 1. A vaginal pessary of conia for ovarian pain, neuralgia or inflammatory. 2. Bromide of potassium, in ovarian menorrhagia, limits the flow, and increases the length of the menstrual interval.

**CASTOR OIL MIXTURE.** The following is a most palatable form in which to administer castor oil:

R. Ol. Ricini . . . . . 5j  
Glycerini . . . . . 5j  
Spts. Lavender Co. . . . .  
Aq. Cinnam. . . . . *aa* ʒss—M.

**QUININE AND TANNIC ACID.**—One and a half grains of tannin will neutralize the bitterness without changing the action of ten grains of quinine. The intense bitterness of the drug renders it almost impossible to administer it to children in its natural state.

**BRITISH DIPLOMAS.**—Dr. O. J. McCully (McGill) has received the M.R.C.S., Eng., and Dr. D. J. G. Wishart, the L.R.C.P., Lond.; Dr. J. Lindsay (Trinity), has received the L.R.C.S., and L.M. Edin.; also N. McKinnon, L. L. Hooper, W. Jacques and J. M. Jackson (Toronto).

**CORONERS.** Dr. F. H. S. Ames, of Brigiden, Ont., has been appointed coroner for the County of Lambton.

The death of Dr. Samuel G. Armor, Prof. of Medicine in the Long Island Medical College is announced; also the death of Dr. W. B. Carpenter, of London, Eng., the eminent physiologist.

### Books and Pamphlets.

LINDSAY & BLAKISTON'S PHYSICIAN'S VISITING LIST FOR 1886.

This is the thirty-fifth year of publication of this excellent list. It contains a calendar, list of poisons and antidotes, dose-tables re-written in accordance with the sixth revision of the U. S. Pharmacopoeia, Marshall Hall's ready method in asphyxia, lists of new remedies, Sylvester's method for producing artificial respiration, with illustrations: diagram for diagnosing diseases of heart, lungs, etc., etc. The quality of the leather used in binding this list has been again improved, and a superior pencil, with nickel tip, manufactured especially for it, has been added.

A CLINICAL HAND-BOOK ON THE DISEASES OF WOMEN, by W. Symington Brown, M.D., Boston, Mass. New York: Wm. Wood & Co.

The volume before us is intended as a practical

guide on the diseases peculiar to women, for the use of medical students and country practitioners. The diseases appertaining to the puerperal state are also included. A chapter is also devoted to gonorrhœa and syphilis. An interesting feature of the work is the grouping together of the different topics in a fourfold arrangement, or some multiple of two, as an aid to the memory. For example, amenorrhœa, dysmenorrhœa, menorrhagia and metrorrhagia; anteversion, retroversion, ante-flexion and retroflexion, etc. Illustrations are introduced wherever they appear of service in the elucidation of the text. The work is well printed on good paper, and is worthy the attention of the profession.

**A SYSTEM OF OBSTETRIC MEDICINE AND SURGERY,** Theoretical and Clinical, for the Student and Practitioner. By Robert Barnes, M.D., Obstetric Physician to St. George's Hospital, etc.; and Fancourt Barnes, M.D., Physician to the Royal Maternity Charity, and to the British Lying-in-Hospital; Illustrated with 231 woodcuts, leather, pp. 834. Philadelphia: Lea Bros. & Co. Toronto: Williamson & Co.

This will be found a most complete treatise on the subject of obstetric medicine and surgery. The wide and varied experiences of the authors are embodied in the work, and it cannot fail to be of great practical value to all who are interested in the subject, and all physicians are more or less so. Though intended for students and general practitioners, it will also be regarded with interest by those specially engaged in this department of science. It is a work of great merit, complete in every particular, and fully abreast of the most recent advances in this department. The text is elucidated by numerous illustrations.

**THE ESSENTIALS OF HISTOLOGY.** Descriptive and Practical for the use of Students. By E. A. Schafer, F.R.S., Jodrell Professor of Physiology in University College, London, Editor of the Histological portion of Quain's Anatomy. 8 vo., cloth, pp. 245, illustrated. Philadelphia: Lea Bros. & Co. Toronto: Vamevar & Co.

Those interested in microscopic anatomy will find this a very excellent work. The directions for preparing and mounting specimens are full and explicit. Only those methods are recommended which experience has proved to be the most reliable and satisfactory. The work will serve as a most excellent elementary text-book in histology,

and we commend it to the attention of those interested in the subject. It comprises all the essential facts of the science.

**THE MONTREAL DAILY WITNESS.**—Published by John Dougall & Son, Montreal.

The publishers are celebrating their fortieth anniversary by an offer of unusual value to their subscribers, consisting of Oleographs by an Art Publishing House in London, Eng., "Little Barefoot," "Nobody Asked You," and "Their Foster Mother." Every subscriber will receive one of these pictures. Any one sending two or three new subscriptions will receive any two of the pictures, and anyone sending four or more new subscriptions will receive the three pictures. The *Daily Witness* is \$3, weekly \$1, and *Northern Messenger* 30 cents per annum.

**THE MEDICAL NEWS VISITING LIST, FOR 1886.**

This is a complete pocket-book of useful memoranda for physicians and surgeons, with blanks suitable for keeping the professional and business records of a practice aggregating thirty patients per day. It is in wallet form, bound in handsome red seal, with tucks, pocket, pencil, and rubber. Price \$1. Thumb-letter index for rapid use, 25 cents extra.

**GRIP'S COMIC ALMANAC.**

This publication for 1886, is to hand. It is brim-full of amusement, containing—besides its other attractions—a double-page cartoon, "Ancient Nursery Rhymes for Modern Politicians." For sale by all book-sellers; only 10 cents.

**THE PHYSIOLOGICAL EFFECTS OF MASSAGE.** Translated from the German of Reibmayr, with notes by Benjamin Lee, A.M., M.D., Philadelphia.

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### Births, Marriages and Deaths.

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On the 31st Oct., Dr. James Carroll, of Norwich, aged 57 years.

On 6th ult., Dr. Slade Robinson, of Toronto, in the 85th year of his age.

On the 9th ult., T. W. Carritte, M.D., of Amherst, N.S., aged 53 years.

On the 18th ult. Dr. L. E. Day, of Harwood, Ont., aged 35 years.

# THE CANADA LANCET.

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## Original Communications.

### INSANITY AND ITS MEDICO-LEGAL ASPECTS.

BY JOHN H. ARTON, M.D., WINNIPEG.

There can scarcely be a more opportune time than the present in Canada, in which to canvass the question, "What is insanity, and what its medico-legal aspects?" We have just passed through a period of excitement, in which these questions have played important parts: and, judging from the amount of irresponsible scribbling that has come, and is still coming to the surface, it may well behove us as dispassionate men, to devote some time and attention to so important a subject. It is proverbially hard to make a definition: and nowhere, perhaps, does the art of defining meet with greater difficulties than here. So far as I know, there is no satisfactory, comprehensive definition of insanity; and, what is more to be regretted, the two professions most interested in this matter, are, perhaps more widely opposed to each other on this, than on any other question. The legal profession has not hesitated, over and over again, to sit upon the medical, with regard to the ideas of the latter on insanity; while the medical profession, has as ably, though without obtaining a conviction, so far, held up its own views.

At first blush, it would appear as though the question should be entirely decided by a medical consensus of opinion, as much as this would decide a question of any other disease: but it is not so, for the question of insanity is made the pivot round which many specially fat tid bit turn: and the gentlemen of the wig and gown are especially gifted in looking after number one. Another reason perhaps for the contempt shown by the legal fraternity for our protests, lies in the prover-

bial facility with which doctors differ. This is owing doubtless to the lack of precision in mental processes, which so many of us, alas! shew;—and which, by the nature of their training, is almost impossible to the legal mind. Medicine has not yet attained the full dignity of an exact science; and, with many in our ranks, it is scarcely a science at all:—and, wherever one is tempted, in a scientific question, to leave the strict lines, and begin to theorize and generalize, he loses his position, as opposed to men who work from a firm and preconcerted basis. It is true that to-day even, it is premature to attempt a definition of insanity: but it is equally true that we have advanced so far along the path towards such a definition as to leave behind, in almost forgotten obscurity, the position held by our legal friends, now, as a century and more ago. It were foolish in us to try to define this disease in its protean characteristics:—to attempt, so to speak, to crystallize in one phrase, or set of phrases, what, by its very nature seems amorphous. We have to fall back on the dictum of one of our greatest poets, which however useless scientifically, amounts to about as much as anything in the same line which our greatest alienists can devise.

"To define true madness! What is it but to be nothing else than mad?" The legal definition, "unsoundness of mind," has the virtue of comprehensiveness: but it is a negation rather than an affirmation. It states what insanity is not, rather than what it is. If however, the courts would advance on their recognition of what *mind* is, we might agree to terms: but so long as they only recognize *intellect* as mind, there can be no agreement.

Physiologists divide the functions of the brain into three—Intellect, Emotion and Will:—and to be sane from a medical standpoint, a man must be sound in all three. The law recognizes these varieties of insanity, in effect, every day, seemingly when it suits its purpose, but the point to which this paper is intended to call attention is that the law does not give due weight to these varieties in the cases of the criminal insane. It is here that oftentimes injustice is done: and despite many efforts, even on the part of the brightest ornaments of the bench and bar, this anomalous state of matters remains from year to year *in statu quo*. I believe, in fact, that the

English law on the subject, as it appears on the Statute Books, recognizes no condition of irresponsibility in insanity. Men who have been recognized as hopelessly insane have been hanged for crimes by the same law which still adorns our Statutes. We can scarcely wonder at this, or regret it either, when we consider the alternative a hundred years ago. Then, the whip, and the rack, and the torture bed, the dark room, the chains, and all the other instruments of torment, which man's ingenuity could devise, were put into requisition in the so-called treatment of the unfortunate lunatic. Better by far a short shrift, and a broken neck, than a miserable existence eked out in such circumstances. Poor clemency that ! But things have changed now, and the treatment of lunatics has a very different aspect. Therefore, if for this alone, it is worth while to rescue those whom the gods have stricken, from a punishment which they in reality do not deserve, and which may well be replaced by a merciful isolation. As time wore on, the horrid injustice of consigning the insane criminal to death, or other punishment, struck even the usually impassive administrator of the law ; and judges were found here and there who actually charged the jury to acquit a prisoner if they found him of unsound mind. In 1843, in a celebrated case, an insane murderer was allowed to escape the death penalty on the plea of insanity, and the people made such a disturbance about it, that the House of Lords propounded a series of questions to the judges for authoritative answers as a guidance in such cases in the future. As far as the present purpose is concerned, the most important answers given was to questions two and three. "To establish a defence on the ground of insanity, it must be clearly proved that at the time of committing the act, the party accused was labouring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing ; or, if he did know it, that he did not know he was doing what was wrong." Here the whole question of responsibility rests on the intellectual capacity of the criminal, *i.e.*, his knowledge. This finding of the judge has never been placed on our Statute Book as law ; but it has been regarded as a law from that time to this. We can recognize what an advance was made here ; and how many really innocent lunatics must have

received the benefit of this amendment. But we hold that to-day, a much further advance is necessary. The law, or rather what stands for the law, provides a loop-hole of escape for a few ; but who among us, in the habit of seeing and dealing with lunatics, fails to recognize that the intellect is often the least affected function. The most hopelessly insane is often exceptionally intellectual. I have myself, when visiting a strange asylum, mistaken an inmate for an official ; and have known lunatics who could solve the abstrusest mathematical problem, and put to the blush nine-tenths of the scholarly among his visitors. Such a man is taken charge of by the state because, perhaps, he has shown some craze, which would lead him to squander his own fortune, and leave his family in poverty. He is not considered capable of managing his paternal acres ; but, if the question is one of human life, he, by the above test is held, and must be held eminently responsible. Moreover, it is not the purely intellectually unstable who are the most likely to come within the clutches of criminal law. It is true, that so interdependent are the various cerebral functions, one upon the other, that in many cases, where one is involved, another is affected also ; but we scarcely can recognize the jurist's pathology who makes insanity first emotional, and later intellectual ; and later still, perhaps, volitional as well. In many of those very cases, where the hardships of the present law tests press most, the accused are purely emotionally insane, with a consequent loss of volition, or control over their actions : and with no appreciable intellectual defect at all. Such men are really dangerous to society ; though perhaps, only at intervals ; and the occurrence of these very intervals of apparent sanity is what becomes most dangerous to themselves, should they ever have occasion to stand the test for criminal responsibility.

This question of insane criminal responsibility, is not by any means a remote one. It is one in which every one of us is directly interested. Probably no man is perfectly sane at all times ; and, though the diagnosis of mental unsoundness may never be made in our case, yet again it may. Sir James Stephens, one of our most eminent English judges, has recognized the narrowness and utter illogicality of the present state of matters ; and has nobly striven to improve them, so far without

effect. English institutions are prone to be lasting from a law down to a wheelbarrow. They are a pig-headed people over there in many respects; and somehow, in this matter, they have failed to be moved; even when right and reason, and eloquence and learning and earnestness were all enlisted to remove a wrong. We are tempted almost to say, that the British representatives have posed successfully as lunatics by their own test. "They do not know right from wrong." Stephens has produced an argument in favour of amending the present test, which for force of reasoning and clearness of diction has few equals. Here is his definition of the disease. Sanity exists when the brain and the nervous system are in such a condition that the mental functions of *feeling* and *knowing*, *emotion* and *willing*, can be performed in their regular and usual manner. Insanity means a state in which one or more of the above named mental functions is performed in an abnormal manner, or not performed at all,—by reason of some disease of the brain or nervous system (*History Criminal Law, Eng. Vol. 3 p. 130*)." Again "criminal responsibility signifies "nothing more than liability to punishment for "crime, and a criminal act implies the existence of "*intention, will* and *malice*." You will notice that he holds for the possession of will in addition to knowledge, in order to make a lunatic responsible. "It is as true," says he, "that a man who cannot control himself does not know the nature of his acts, as that a man who does not know the nature of his acts, is incapable of self control." (p. 171). This man ought to have been a doctor rather than a lawyer. In 1874 Stephens compiled a bill entitled "A Bill to amend the law of Homicide" in which it was provided that homicide should not be deemed criminal if the accused person is at the time of committing the act prevented by any disease affecting his mind. (a). from knowing the nature of the act: (b). from knowing that it is forbidden by law: (c). from knowing that it is morally wrong: (d). from controlling his own conduct. The fourth test is in reality the amendment to any previous legislation, or authoritative findings on the subject. This Bill was not passed: and consequently we stand as we were. While admiring the liberality of Sir James, especially for a legal mind, we must confess that even his tests are inadequate to estimate such a subtle disease as insanity.

To attempt a summing up so far, our position at present simply is,—“Most jurists aver that no “degree of insanity should exempt from punishment “from crime, unless it has reached that point that “the individual is *utterly unconscious* of the difference between right and wrong at the time of “committing the alleged crime.” On the other hand, physicians who have given this matter a careful study, affirm that this test would only apply to persons suffering from delirium; from a furious paroxysm of mania, or from confirmed idiocy; that persons suffering from confirmed insanity are fully conscious of the difference between right and wrong: and are quite able to appreciate the illegality, as well as the consequences of their acts. Some jurists hold that the law means *the consciousness of a sound mind* when it proposes this as a test, and that “the consciousness of the insane, is an insane consciousness.” But this is simply begging the question. It may be true that in practice the English law differs from the same law in theory: and that practically it cannot be said to err on the side of severity. The fact remains, however, that it operates with uncertainty: and that, if possible, is a graver charge.

With regard to Canada, at least, the remedy lies in our own hands. There is no reason why we should supinely wait for the mother country to take the initiative in this matter of reform. It were well once in a while to shew that our boasted independence is not a pure myth, and that we can dare at least to think for ourselves. It is evident from recent events, that this same test of knowledge of right from wrong is taken in this country as the test of insanity. (see ex-Min. Jus. Campbell's Manifesto on the “Riel trial.”) The popular test here, as at home, is “does he know right from wrong?” If he does, then he is not insane: or at least not legally, or popularly insane. The elasticity of this definition if rigorously enforced, would throw open the gates of our asylums to many, who, for the safety of the commonwealth are now immured. It besides being within reach of the halter all those, who, from motor explosions (epileptics and acute maniacs) may commit murder: and, in the next hour or minute, when examined, be perfectly sane. As medical men, we know and recognize epilepsy and mania to be first cousins, but lawyers do not. Both diseases are

explosions; the one a "muscular storm, the other a storm of thought, emotion and will." After the storm has passed who can detect the difference oftentimes between the sound and the unsound?

The question of hallucinations again here presses itself on our attention. They are not always the result of imponderable undetectable changes, as so many think. In many cases these hallucinations can be clearly traced to gross and palpable lesions of the optic thalami or their plexuses. These cases are accompanied usually by atrophy of certain convolutions, which is recognizable even by the naked eye. The law takes no notice of this. I do not know how to diagnose with certainty such a condition during life. If the symptoms of lesion, of what is improperly styled "the internal capsule" be wanting, there may be nothing to lead one to these intellectualizing ganglions at all. Cross lesions, which interfere with the motor apparatus, and whose locality is much more easily appreciated, be the same in the cortex, the cortico striate fibres or the corpus striatum itself, do not so frequently have a bearing on insanity, as do lesions of the sensory areas. But because you or I cannot positively say in any given case, that a man's hallucination depends on a given lesion while he yet lives, that is no reason why he must be hanged in order to oblige us with a post-mortem. And, by the way, when such judicial proceedings have been enforced, with or without protest from our side, why should not a properly managed post-mortem be held for the satisfaction of all concerned, and the furtherance of science. It is all very well to have a coroner's inquest in order to certify that the criminal is really dead; but to that should certainly be added a careful and scientifically conducted *sectio cadaveris*.

These somewhat disjointed remarks (to which perhaps I should prefix Montaigne's motto "I have gathered a bouquet of other men's flowers and only the thread which binds them is mine own,") will have done almost more than their author hopes for, if they conduce to a discussion of the subject by men abler to deal with the new question from every point than himself. There can be but one opinion, one would suppose, among all professional and lay, as to the expediency of having this legal gap in our institutions filled up. The people at large accept things as they are, partly from ignorance of facts and partly from lack of interest.

The medical profession here, as in almost every matter of reform, becomes of necessity the leader and adviser of the laity. The popular idea of what constitutes insanity must be dissipated; together with the error that it only needs common sense to discriminate between a sane and an insane man. In truth, it needs more acumen, skill, judgment and special education probably, than any other problem we are called on to solve. And how often do the best make mistakes or fail in arriving at a conclusion. Let any one read the medical evidence in Lady Mordaunt's trial, where the most distinguished men, not only of that time, but probably of all time, investigated the question of her sanity; and how humiliating the confession we have to make, that their investigation amounted to nothing. Fortunately such cases do not arise every day. Who among our sapient editors, etc., who so glibly pronounce on questions of such fine spun yarn, would consider the author of the following lines insane:

"There is a winter in my soul,  
The winter of despair;  
Oh, when shall spring its rage control?  
When shall the snow-drop blossom there?  
Cold gleams of comfort sometimes dart  
A dawn of glory on my heart,  
But quickly pass away;  
Thus Northern lights the gloom adorn  
And give the promise of a morn  
That never turns to day."

And yet he was a confirmed lunatic when he wrote these lines, which with almost incredible faithfulness and clear insight portray his condition and the mental disease from which he died.

As remarked before, it is a subject which is not remote to anyone. Besides, the old maxim "*Nihil a me alienum humanum puto*," every man has a personal and living interest in the question of mental alienation, and the responsibility dependent on that condition. Let the Dominion House of Commons take up the matter. Let the dead past bury its dead! We are the heirs of the future! Let a committee be appointed, say of the medical men in the House, with others, if deemed necessary, to investigate this question; and to formulate such amendments to our law on the subject as will prove a model for the mother country well worthy her imitation. By doing this our parliament will confer a lasting boon on the world at large, and deserve lasting paeans of praise from all men for all time. To break free from the trammels which a bigoted and purblind judiciary

has imposed on us for all these centuries, is a task worthy to be classed with the emancipation of slaves, or Magna Charta itself.

If by any chance, this suggestion should, even in the remote future, lead to such a desirable result, it will be only another of the boons conferred on a somewhat ungrateful public, by a profession, whose humblest member has for his motto,

"PRO BOZO PUBLICO."

## INTESTINAL OBSTRUCTION.

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In these days when surgery is making such immense strides in the treatment of abdominal diseases, which only a few years ago were deemed beyond the resources of our art, it may not be without interest and profit that the subject of intestinal obstruction should be brought before this Association. Under this head it is our intention to review briefly the various diseases which lead to obstruction of the bowels, with the exception of course of hernia, which obviously belongs to a different class of cases. Much of that which I have to offer will be derived from the writings of different authors, especially from the Jacksonian prize essay of Mr. Frederick Treves. I have myself, however, met with seven cases of acute intestinal obstruction during the last five years, two of which were seen in consultation; and if I should judge from my own experience during the last fifteen years, I should consider cases of this disease to be more common than idiopathic peritonitis, with which I fear they have been too often confounded. From a clinical standpoint, cases of obstruction may be best divided into two groups, viz., acute or subacute, and chronic. Many of the latter, however, have an acute ending.

Under the first division may be arranged—1st. Cases of strangulation by bands; 2nd. Cases of volvulus; 3rd. Cases of acute intussusception; 4th. Some cases of obstruction by foreign substances. *Chronic* cases include: 1st. Stricture of the intestine; 2nd. Faecal accumulations; 3rd. Chronic intussusception; 4th. Some cases of obstruction by foreign bodies.

Strangulation by bands or through apertures give rise to symptoms which are typically *acute* in their courses, and which resemble closely those

of a strangulated hernia. The similarity is rendered more marked by the fact that in both it is usually the small intestine that is involved.

Under this variety of intestinal obstruction may be placed:—1st. Strangulation by peritoneal adhesions; 2nd. Strangulation by cords of omentum; 3rd. Strangulation by Nuckel's diverticulum, the vermiform appendix, the pedicle of an ovarian tumor, and the like; 4th. Strangulation through slits in the mesentery or omentum, or through membranous adhesions.

The varieties of the foregoing class are so numerous that for practical purposes it must suffice to say that the constricting cords are of various lengths and sizes, some being found long enough to form a knot in which the gut is included, while others are so short that scarcely room enough is obtained for the application of a ligature, the lumen of the intestine being closed as in one of my cases by dragging upon the contiguous loops. Furthermore, these bands may be attached to every conceivable part of the bowel or abdominal wall. According to Treves, this form of acute obstruction occurs more frequently in males than females, the proportion being about 3 to 2. As to age, most cases are found between 20 and 40 years, being very rare before 10, and comparatively infrequent after 40. In 68 per cent., there was a previous history of some trouble which would be likely to have produced causes of obstruction. In about half of the cases this was peritonitis; in others a history of hernia; and in some few a history of accident.

In only a small proportion of the cases analysed (12 per cent.) was there any evidence of previous symptoms of obstruction, the attack reported being the first suffered from.

*Volvulus*, the 2nd form of acute obstruction, includes two varieties, one in which the bowel is twisted on its own mesentery or on its own axis, and another in which two coils of intestine become intertwined. The most frequent seat of volvulus is the sigmoid flexure of the colon, two-thirds of the cases reported having been found to involve that portion of the intestine. It occurs much more frequently in males than females, the proportion being 4 to 1. The great majority of cases falls between the ages of 40 and 60. Very often a previous history of constipation has been noted in this class of cases.



*Intussusception*, which represents the next form of acute obstruction is one very commonly met with, about one-third of all the cases being made up of this variety. Nearly one half of those reported were of the ileo-cæcal kind, next in frequency was the enteric, then the colic, and lastly the ileo-colic. More than 50 per cent. of all cases occur during the first ten years of life, and about 25 per cent. in infants under a year. In this respect intussusception differs remarkably from the two preceding forms of acute obstruction. The most common exciting cause noticed has been diarrhœa; but, according to Treves, only about 10 per cent. were preceded by this disease. In all three cases of my own, diarrhœa preceded for a day or more the establishment of marked symptoms of obstruction. One of the most striking as well as frequent concomitants of intussusception is the *passage of bloody discharges*. About 80 per cent. of the acute cases presented this symptom, and about 50 per cent. of the chronic ones. In a very large proportion there was also a marked degree of *tenesmus* present, especially in the more acute cases. A third distinguishing feature of intussusception is the presence of a more or less distinct tumor, which may be felt in about half the cases, and is apt to grow harder and more defined during a paroxysm of pain. It varies in size from that of an egg to that of the forearm, and as a rule is more or less fixed. Its length may be as much as 5 or 6 inches or more. In nearly one-third the cases the lower end of the tumor projected from the anus, or could be felt by the finger in the rectum. The *Chronic* forms of intussusception are more difficult to diagnose than the acute, and the symptoms may be protracted for months. Diarrhœa very commonly alternates with constipation in these cases, and there are intervals when the patient seems to be in fair health, although more or less emaciation necessarily accompanies the malady in its progress. Spontaneous relief may take place in any case of intussusception either by reduction of the bowel, with or without the assistance of opiates, or by sloughing of the invaginated portion and union of its ends. A partial recovery occurred also in one case reported, when a faecal fistula formed about the seat of obstruction.

We come now to a consideration of the 4th class of acute obstruction, namely, that caused by the presence of a foreign body. More frequently,

however, the symptoms produced by such pursue a more or less chronic course, although the final result as in chronic intussusception may be brought about suddenly. These substances are of course found to be of various composition and character, and are introduced into the alimentary canal by swallowing some hard or indigestible material, which, either singly or by accumulation, brings about obstruction. Among the largest of these masses may be mentioned those composed of cocoa-nut fibre or hair. In one instance one of the former weighed 4 lbs.; and I myself saw Mr. Knowlesly Thornton remove a mass of hair and thread from the stomach of an hysterical young woman, which measured  $9\frac{1}{2}$  inches in length, and was  $2\frac{1}{2}$  and  $4\frac{1}{2}$  inches in diameter at either end.

In Mr. T's case, however, little or no obstruction to the passage of food was caused, and the patient was fairly well nourished. Allied to this class of cases are those in which one or more gall-stones or intestinal calculi are the cause of symptoms of obstruction, which are generally subacute or chronic in character. A tumor can of course be often detected in all these varieties of the 4th class of obstruction.

Turning now to the consideration of the 2nd great division of our subject we shall find *stricture* of the intestine the best representative of the causes giving rise to chronic obstruction. In almost all instances of such there will be got a history of previous attacks, somewhat similar to that which has led to complete obstruction. The rule is for these attacks to become more and more frequent as well as severe up to the end of the case. Among the anatomical lesions found are simple contraction due to the healing of former ulcers, stricture from former hernie and old injuries, and finally that resulting from epithelioma and other growths in the intestinal wall. Cases of *stricture* generally occur between the ages of 20 and 60 years. Closely allied to stricture are those cases in which the gut is closed by the pressure of tumors, abscesses etc., from without. In most of these the obstruction is situated in the rectum or sigmoid flexure, for the reason that the swellings producing it are most frequently met with in the pelvic region. They differ from cases of stricture in being much more frequently acute in symptoms.

*Fæcal accumulations*, when giving rise to in

testinal obstruction, may generally be easily diagnosed from the history, coupled with the presence of a tumor, which can be more or less easily indented by firm and steady pressure of the finger.

Chronic intussusception and obstruction from foreign bodies having been already referred to, we will now turn our attention to the important subjects of *diagnosis and treatment*.

In reference to *diagnosis*, we will first enumerate the prominent features of most cases of acute obstruction. The symptoms are generally extremely *abrupt* in their onset, and may be briefly named as follows: 1st, severe pain in the abdomen, followed rapidly by frequent and persistent vomiting; 2nd, often after a few hours, there supervenes more or less meteorism, which however may be localized, and occasionally even, when the seat of obstruction is high up, may be entirely absent; 3rd, we have as a rule from the first absolute constipation, not even flatus passing per anum; 4th, after a shorter or longer period, depending upon the acuteness of the symptoms, there will appear a collapse: which is often attended by either intestinal or faecal vomiting.

The diseases with which acute obstruction is most likely to be confounded are perhaps acute peritonitis due either to perforation or other causes, cholera and dysentery. Acute peritonitis is the more apt to be mistaken for acute internal strangulation, for the reason that quite frequently cases of the latter disease have the former developed during their progress. If, however, one is called early in the case, he will find several points of difference, which will pretty certainly fix the diagnosis. In peritonitis the temperature is generally considerably raised, while in acute obstruction it is as a rule subnormal, becoming perhaps elevated some days afterwards from the supervention of inflammation. Tenderness is a marked symptom in peritonitis, while there is an almost or entirely complete absence of it in the other disease. This gives rise to a striking difference in the attitude and behaviour of the patient. In peritonitis, he of course usually assumes the dorsal decubitus with knees drawn up, and is unwilling to move or be moved. In cases of acute obstruction, however, he writhes about in bed, assuming all sorts of positions, or gets up and walks about the room like one suffering from an ordinary attack of colic, while he is even also

relieved sometimes by pressure as in that affection. Again we have a diagnostic symptom of much importance, namely, the existence of rigidity of the abdominal muscles, giving rise to a *board-like* feel; in cases of peritonitis, which contrasts strongly with the flaccid and soft abdominal walls in obstruction. Also, vomiting is a much more prominent symptom in strangulation, and becomes after a few days either intestinal or distinctly stercoraceous. It is exceedingly rare for it to attain such a character in peritonitis, and then generally only at the close of a fatal case. Furthermore, constipation is almost invariably absolute after obstruction has become established; except perhaps in cases of intussusception, which however, on account of the bloody discharges that are generally present, are not likely to be confounded with peritonitis. It is only the ultra acute cases of intestinal obstruction which would be mistaken for an attack of cholera, such as strangulation near the stomach or acute cases of intussusception in very young children. The prevalence of the epidemic at the time may aid us in deciding between them, while cramps and a severe diarrhoea accompanied with rice water discharges would generally serve to make us sure of the diagnosis. From dysentery we may generally readily diagnose obstructions by the absence of febrile disturbance, and by the greater severity of the pain and vomiting. From my own experience in three cases, where I had I think good grounds for believing that I was dealing with intussusception, I would be inclined to lay considerable stress upon a difference between the discharges of dysentery and those of intussusception, to which no one as far as I am aware has called any special attention. I was myself particularly struck by the *bright-pink* colour of the serous dejections in these cases, which seemed to me to contrast very remarkably with the dark dirty hue of those of dysentery. In my cases also I saw very little if any mucus, though the absence of this may have been due to the fact that the rectum was not involved, no tumor being felt by the finger per anum. Furthermore, any blood seen was of the same bright red colour, and thus differed materially from the dark clots generally observed in cases of dysentery.

Although the diseases above referred to are perhaps the chief of those which may be mistaken

for acute obstruction of the bowels, yet there are several others which resemble it more or less closely, but which can be usually easily enough distinguished from it by the previous history of the case, and by the presence of some well-known diagnostic symptom. It must suffice merely to enumerate in this connection the following:—hepatic, renal, or lead colic, cases of acute irritant poisoning by arsenic, or some similarly acting substance, acute meningitis, etc. Strangulated hernia is of course always to be thought of, and search made for any of its various forms.

Having made a diagnosis of intestinal obstruction, let us now consider the kind of *treatment* applicable to the disease in its different forms; and first we will pass in review a few of the non-operative measures which may be resorted to in dealing with such cases. Opiates undoubtedly occupy a prominent position, and are of much service both in relieving pain and retarding the symptoms of collapse, while at the same time they tend to promote a cure by preventing the irregular peristaltic action of the bowels, which acts so potently both in the production and continuance of many attacks of the disease. They would be especially useful in acute intussusception and volvulus. Next come enemata and insufflation of air. The enema generally employed is simple warm water, to which is sometimes added soap, ox-gall, or oil to aid in softening and rendering fluid any fecal mass that may be present in the colon. It has been affirmed that injections cannot be made to pass beyond the ileo-caecal valve, and would therefore be useless in affections of the bowel above that point; but it is now we think pretty generally admitted that they do often overcome this barrier, especially if the patient be well under the influence of an opiate or anæsthetic. In order to render the enema more effective, it is often advisable to introduce a long flexible tube, such as that attached to a stomach pump. Great care will be required to pass this successfully, for it will otherwise often coil itself up in the rectum, instead of moving on into the colon. We have derived on many occasions much benefit in making this manœuvre, by occasionally throwing in a few ounces of water, so as to distend the gut, and thus lessen the chances of the end of tube bringing up against its walls. Also we think a cork-screw-like motion will often materially assist it in its

onward progress. The cases most likely to be relieved by enemata are intussusception and obstruction from faeces; also perhaps some cases of volvulus, where indigestible articles of diet have given rise to the disease. Insufflation of air is said to have proved successful in reducing an intussusception after enemata of warm water have failed. In order to prevent the escape of the air or fluid where large quantities are injected, an obturator of cotton rag or an inflated rubber ring may be used. Aperients are to be condemned in all cases of acute or subacute obstruction. They may however be employed in chronic faecal accumulations, although it must be seldom even in these that enemata will not prove as good and a safer remedy. Recently, in Germany, washing out of the stomach and small intestine by means of the stomach-pump or by syphon-action, has been employed in obstruction cases. It is claimed that by thus emptying the distended alimentary canal above the seat of disease, the bowel will be placed in a condition more favorable for spontaneous relief.

Metallic mercury, which at one time was held in high repute in the treatment of obstruction, and subsequently fell into disuse, has again been extolled of late in France as a remedy, especially in cases of stercoraceous accumulations. It is not supposed to act simply by its weight, but is thought to insinuate itself in a condition of fine division between the intestinal wall and the obstructing mass, and thus helps to loosen the hold of the latter and consequently aids in its expulsion. In several such cases M. Matignon reports prompt relief from its use, after purges and enemata had failed to dislodge the offending substance. The doses administered varied from two to eight ounces, and were in most cases several times repeated. In one case nearly 2 lbs. were taken altogether and with success. No ill effects were ever observed from the remedy. Massage and electricity have also been used with advantage in some of these cases, but they will probably be found rather to occupy the position of adjuvants to other methods of treatment than otherwise. Indeed, manipulation of the tumor of an intussusception materially aids an enema or insufflation in bringing about reduction: and it is easy to understand that in cases of faecal accumulation when no inflammation is present, it may also be of great service.

Finally, let us consider the operative procedures which may be undertaken for the belief of intestinal obstruction. If rest in bed with abstinence from food, one or more full doses of morphine, a few large enemata through a long tube, and one or two washings out of the stomach do not succeed in bringing relief in a case of *acute* obstruction within two or three days, it is advisable to perform laparotomy without further delay. Heretofore the operation has been usually put off for a much longer period; but with our improved knowledge of these cases, and consequent more early and certain diagnosis, an earlier resort to opening the abdomen will without doubt lead to much better results. Besides, since it has been learned that the peritoneal cavity is not such a sacred or dangerous precinct to invade as was once thought, there need not now be such hesitation in undertaking the operation. It is pretty generally admitted that delay is more to be blamed for previous bad results than the operation itself. According to past statistics only about one recovering out of three have been reported, and it is more than probable that if all cases had been made public the proportion of unsuccessful ones would have been found to have been considerably in excess of that estimate.

The operation is generally performed in the median line below the umbilicus. When we have opened the abdominal cavity we proceed to search for the cause and position of the obstruction. When this does not immediately appear, we may generally find it most readily by feeling for the collapsed coils of intestine, which as a rule lie below the brim of the pelvis, and tracing them upwards to the point of disease. Having discovered this we will have to vary our course of action according to the cause of the obstruction and the condition in which we find the parts. If a band or cord be the source of trouble we must divide it, two ligatures having been applied, one on either side. In cases of strangulation through slits or apertures, it will be advisable after reduction, to close the opening by suture. It is well also in all these cases to examine the parts carefully in order to ascertain whether or not there may be more than one constricting band present, for in some instances such have been found at the autopsy.

Cases of volvulus are not well suited for relief

by laparotomy, as it is found difficult to deal with the enormous dilated coil of sigmoid flexure, which is generally the seat of the disease. Puncture of the gut may be employed to relieve the distention and thus enable us to reduce the part; but the volvulus is apt to reappear after a little time. A case of my own, which I think was one of this form of obstruction, finally recovered after a dozen or more punctures through the abdominal wall with a small hypodermic trocar. The punctures were made at different times during the several days that the excessive meteorism lasted, and seemed on each occasion to afford marked relief. I would advise caution however in puncturing the distended bowel in such cases, for there can be no doubt that unless the instrument used be very small there is danger of extravasation of the intestinal contents through the openings made in the gut. I know that such oozing from the punctures may, and does occur, for I have seen it in two instances in which, after laparotomy had been performed, I was obliged to let out the gas from the distended coils of intestine before I could return them into the abdominal cavity. After a few minutes, however, the openings seemed to close sufficiently to prevent any further exit of fecal matter. One of these cases recovered and the other lived till the 7th day after the operation, so that I think the punctures did not lead to any serious complication. And here, let me say that the great distention of the bowel met with in these cases gives rise to the chief difficulty in performing abdominal section for the relief of intestinal obstruction. It is almost if not quite impossible to prevent the distended bowel from escaping externally, and it is equally impossible to put it back in its place before its size is reduced by puncture. I would be inclined to try the insertion of a gum elastic tube into the colon in cases of volvulus, so as to permit of the escape of gas by that method. If all else fails, a fecal fistula can be established above the seat of obstruction.

When a portion of intestine is found to be gangrenous, whether in cases of intussusception or other form of obstruction, it must be excised. After doing this it is considered better in all cases (except those in which the upper part of the small intestine is involved), to secure the cut ends of the bowel by sutures to the abdominal wound, rather than to proceed at once to unite them to each

other; because the increased length of time required to complete the latter operation would very much augment the shock produced, and consequently be much more likely to lead to a fatal result. On a future occasion, if the patient recovers, that object can be attempted under a much more favorable condition of things. When practicable, cases of *stricture*, whether due to simple constriction or caused by cancerous or other growths, are to be dealt with by resection of the bowel and removal of the diseased mass, the ends of divided gut being attached as above mentioned to the external wound. When excision is inadvisable or impossible, an artificial anus must be made. When the seat of disease is known to be in the sigmoid flexure or rectum, left lumbar or inguinal colotomy may be at once resorted to if thought best, without a previous central abdominal opening being made. Cases of *simple* stricture may generally be temporized with for some time before it will be necessary to operate for their relief. Much may be accomplished in this way by careful dieting and the use of nutrient enemata. When, however, we have good reason to suspect malignant disease, it is a question whether it will not be better to excise the part early, so as to afford the patient some chance for a permanent cure.

An *intussusception* is of course always to be reduced if possible. When too firm adhesions have already formed to permit of this being safely done, it is probably better to at once cut away the invaginated portion, and secure the ends of gut to the laparotomy wound. Every precaution must of course be taken in all resections of the intestine to prevent the escape of its contents into the peritoneal cavity. If a *calculus* or *foreign body* prove to be the cause of trouble, the bowel may be laid open and the offending substance removed, unless indeed it can be readily moved along towards the anus. In case the gut has to be cut into, the wound must be carefully approximated by fine silk sutures in such a way as to bring the peritoneal surfaces closely together. In cases of obstruction from *faecal accumulations*, we can afford to delay operative measures so long as there is any prospect of getting rid of the mass either by enemata, metallic mercury, cathartics, or manipulative procedures, and it must be seldom indeed that these will not suffice to afford relief.

## RHINITIS ATROPHICA—WITH REMARKS ON CATARRH IN GENERAL.

BY G. STERLING RYERSON, M. D., C. M., L. R. C. S. ED.

Lecturer on diseases of the Eye, Ear, Throat and Nose, in Trinity Medical College, Toronto.

To the practitioner in general, the nature, pathology and treatment of catarrh are as an unopened volume, and the word is only too often associated in his mind with incurability. To the public, the word is almost synonymous with offensive breath, and it is popularly believed that is the forerunner and friend of consumption. These ideas have been assiduously fostered by designing persons, and the country has been overrun with catarrh doctors and nostrum vendors of all sorts. It is with a desire to put the facts in a clearer light that I am induced to pen these lines.

In the first place the question will naturally arise what is catarrh, ? It has been shown by Bosworth, Cohen, and others, that it is an inflammation of the lining-membrane of the nose—a rhinitis—and like inflammations in other parts ends in resolution, in hypertrophy, in ulceration, or in atrophy. It is liable to extend to the pharynx trachea and bronchia. I do not know that it has ever been proved to cause tuberculosis. Bronchitis and asthma are often caused by it. Contrary to the generally received opinion fetor is the exception rather than the rule, not more than five per cent. of the cases being attended by this symptom. It is probable, though not yet certain that all the varieties of catarrh are but different stages of the same complaint. Thus we see rhinitis simplex in the father followed by rhinitis atrophica in the child. It is remarkably hereditary, and occurs in many members of the same family.

Now as to the varieties of catarrh. The first and commonest is *rhinitis simplex*, characterized by an excessive flow of mucus, worse in damp weather, and when the patient's general health is not good. There are no organic changes visible on examination of the part; no fetor.

*Post Nasal Catarrh* is a very common variety of simple rhinitis, affecting the pharyngeal vault and upper pharynx. The nasal mucus membrane may also be affected. The glandular structures are often hypertrophied. The symptoms are dropping in the throat, discharge generally worse in the morning, causing hawking and peculiarly disagree-

able nasal secretions, hoarseness in the morning wearing off towards noon, and deafness from Eustachian tube and middle ear catarrh.

*Congestive rhinitis* or erectile catarrh is an inter-current condition, generally associated with rhinitis simplex. Sudden closure of the nasal passages on one or both sides is the principal symptom. It passes off after a variable time, and is followed by a profuse flow of clear mucus. It is due to a sudden engorgement of the venous sinuses of the nose.

*Hypertrophic rhinitis* is a true hypertrophy of the epithelial glandular and connective tissue elements of the pituitary membrane. The amount of discharge from the nose is as a rule not very considerable. It is satisfactorily treated by means of the electro-cautery. Evulsion of the membrane I only mention to condemn.

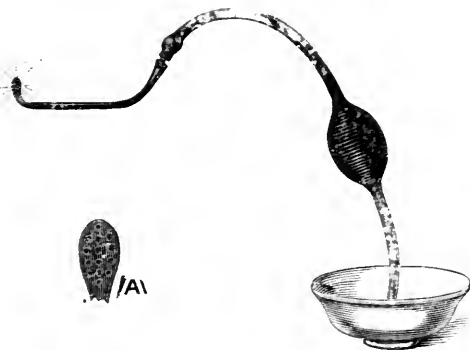
*Ulcerative rhinitis*, is frequently confined to one nostril. It sometimes goes on to the formation of an abscess in the nose. It may also cause perforation of the septum. Caries is an occasional accompaniment. The nostril affected is swollen, reddened and painful to the touch if the affection is acute. If chronic, it is unattended by pain, but hard crusts form which are attended with some discomfort. The nose bleeds easily when touched. I do not include in this group cases of syphilitic diseases of the nose.

*Ozena*. By this term I mean discharge of offensive matter from the nose, unattended by apparent change in the mucous membrane. The disease is not in the nasal cavity itself, but in the accessory cavities. The prominent symptom is the discharge of large quantities of fetid muco-pus mixed with blood, and various foreign substances deposited by the inspired air. The causes cannot be laid down with certainty. It may result from general debility, but is quite as apt to be found in persons of good constitution and robust physique. I think that the term *Ozena* should be restricted to this form of disease, and not applied to all forms of offensive discharge from the nares.

Fetid nasal catarrh or *rhinitis fetidus*, is a condition resulting from a long continued atrophic rhinitis, or dry catarrh. It is attended by the discharge of exceeding fetid masses of dried mucus. The odor is very penetrating and will remain in one's consulting room for some time after the patient has gone. The bones are atro-

phied and the nose is often flattened as the result of the preceding atrophic catarrh.

*Atrophic rhinitis*, a form of nasal disease which forms the heading of this paper—is an affection growing out of rhinitis simplex or hypertrophica, as I believe from clinical observation, and presents the following symptoms: Excessive irritability of the parts with more or less tingling and pain. The sense of smell is generally impaired; thin, dry, closely adherent crusts make their appearance. Their colour is grayish yellow or greenish, and they consist of inspissated muco-pus mixed with various impurities. They are very tenacious and difficult to detach. There is a constant sense of discomfort in the nose and this is increased to actual pain if the temperature of the inspired air be much lowered. The thin crusts soon become thicker and harder. A thick viscid fluid is poured out of the membrane. This dries very quickly and forms crusts. They have a peculiar and musty odor, not highly offensive as in fetid catarrh. Superficial ulcers form on the mucous membrane, having a grey unhealthy look. The pharynx is sometimes involved giving rise to a dry, glistening condition; highly uncomfortable to the patient. Upon examination of the part, the mucous membrane will be seen to have a peculiarly dry parchment-like appearance. The nasal cavity will seem to be ex-



ceedingly spacious, owing to the atrophy of the turbinated bone. Masses of dried muco-pus may be seen adhering to the parts. If these be removed the membrane will be found to be reddened and occasionally presents superficial ulcers.

As regards the *treatment* of this this variety, the indications are:

1st. Thorough cleansing; 2nd. Stimulation, to render discharge fluid; 3rd. Gradual arrest of discharge. The cleansing can be effected by means

of a hard rubber syringe with a large nozzle in the hands of the physician. The patient will find the douche made by Stevens & Son of this city, after my instructions, to be convenient. The gravitation douches, as Thudichums, are dangerous, as they are apt to drive the water up into the middle ear and cause acute suppuration of that cavity. Any crust that remains should be gently removed by the forceps or probe. It generally takes several days to thoroughly cleanse the parts, and until this is done it is useless to do anything else. Once accomplished, it must be kept up by the free use of salt and water by the douche, once or twice a day. Then stimulation can be used according to the following formulæ :

R	Argent nit.	grs. $\frac{3}{4}$ ;
	Amyli pulv.	grs. 154—M
R	Argent nit.	grs. $1\frac{1}{2}$
	Amyli pulv.	grs. 154—M
R	Argent nit.	grs. $2\frac{1}{3}$
	Amyli pulv.	grs. 154—M

Gradually increasing strength of powders to be insufflated. Or the following :

R	Pulv. Sanguinariae.	
	Pulv. Myrrhae	aa 3 i.
	Lycopodii pulv.	3 ii.
R	Pulv. Galangae	
	Pulv. Amyli	aa 3 i.

Having fulfilled these indications, use a mild astringent as Zinci Sulph., Zinci Iodid., Alum. or Tannin, about five grains to the ounce, in the form of spray. When the treatment is systematically and carefully carried out, I venture to predict a satisfactory result—not merely in this but in all varieties of catarrh. It is obvious from what I have stated that a successful result depends upon a proper diagnosis and the selection of the remedies for the variety of catarrh in the given case. The general health will in most cases require attention on the usual principles, and will require modification to meet any special symptoms which may arise.

### Correspondence.

#### UNPLEASANT EFFECTS OF ANTIPYRIN.

To the Editor of the CANADA LANCET.

SIR. While using drugs of recent introduction, it is well, if not our bounden duty to the profes-

sion, to place on record any unusual and especially any alarming symptom that may present itself. Antipyrin is of comparatively recent date, and has been considered perfectly free from danger in doses of 30 grains repeated.

Prof. Stewart, of McGill College, Montreal, in his excellent report on Antipyrin, quoting from Pavay, states "That collapse never occurs, that it possesses marked advantages on account of its freedom from dangerous effects."

The following case seems to show that there may be some exceptional effects produced by the use of this remedy. On the 7th of Oct. last I was called to Mrs. B., æt. 45, a patient in the fourth week of typhoid, whom I had been attending, and considered convalescent. Her temperature was 103.6°, pulse 120, respiration 30, fine crepitation throughout the lower portion of both lungs. I thought Antipyrin the best selection as an antipyretic, judging that it would produce less depression than either quinine or salicylate of soda. I happened to have with me just one dram and divided it into five equal powders of 2 gr. each. I ordered one every three hours. Next morning early a messenger was sent with the unwelcome news that the patient was dying. On my arrival I found her in a state of severe collapse. Cold perspiration stood in drops over her face and parts of her body, cold hands and feet, temperature 95°, pulse feeble and flickering, impossible to count it. I was, indeed, alarmed, and expected to lose my patient. I immediately gave her ammon. carb. and digitalis, with whiskey at short intervals, and applied artificial heat around the body. I was very much pleased to find that this treatment counteracted the unpleasant symptoms, and am still further pleased to know that the patient has ultimately recovered. Two or three days afterwards her daughter drew my attention to a patch of purpuric macule about the size of the palm of the hand on the back, just below the seventh cervical vertebra. This was, no doubt, the characteristic eruption that results from the use of antipyrin, but it was not observed on any other part of the body.

As antipyrin lowers temperature by dilating the capillaries of the skin and exposing a large volume of blood to the external temperature, I think, in a case of this kind digitalis would prove a valuable antidote by its contractile effects upon the arteri-



oles. Perhaps my selection of the conditions was not judicious for the administration of antipyrin : but, even granting that, the above is a sufficient warning for me, at least, to feel my way with caution before administering doses of 30 gr. Since the above case occurred I have observed two cases, with similar results, recorded. One, also, in a typhoid patient, almost exactly similar by Strauss in *Berlin, Klin. Wochenschrift*.

Yours, etc.,

W. GRAHAM.

Brussels, Ont., Nov. 23, '85.

To the Editor of the CANADA LANCET.

DEAR SIR:—Do you not think it is time for the medical profession to resent the pestering questionings, about our private business, by parties who are paid for looking after the sanitary arrangements of the country? We have spent years of the best of our lives and considerable means, to qualify ourselves for the practice of our profession, so as to gain a living for ourselves and families; and many of us can hardly make both ends meet. Yet we are continually being pestered and hectored to tell every body all we can, so that no one will need to employ us: so that we may live on the wind and be laughed at for our pains.

It is all right, and the bounden duty of Government to look after the health of the people: but, it is a piece of gross imposition to expect medical men to help them without any remuneration. Our present Local Government is composed chiefly of lawyers; let them try to get their brethren to unite and answer all kinds of questions for the guidance of the public, so that there will be no litigation, and see how they will succeed.

But after all, it is the medical men themselves who are chiefly to blame. If they would just decide to answer no professional questions unless accompanied by the usual fee, the pestering would soon cease. Can you give any sound reason, why they should do otherwise?

ANTI-HUMBUG.

December 14th, 1885.

ERYTHEMA OF FAT PEOPLE.—Dr. E. J. Kemps says: For the erythema and itching between the thighs and on the buttocks of fat people, either calomel or bismuth subnitrate, rubbed on dry, will make you proud of yourself.—*Louv. Med. News*, Sept. 12th.

## Reports of Societies.

### HAMILTON MEDICAL AND SURGICAL SOCIETY.

Nov. 3rd, 1885.

Regular meeting, Dr. Stark, Vice-President, in the chair.

Dr. McCargow exhibited a specimen of glioma of the brain. The patient had been under the care of Dr. G. L. Mackelcan, German, aged 40, married but separated from his wife because he did not support her: had acted strangely a few days before his admission to the Hospital, on the 17th of Oct., 1885. He was morose, would not answer questions. He walked with assistance with a shuffling gait. He seems drowsy, but when roused answers questions and then relapses into the drowsy state again: complains of pain across his forehead. There is no loss of tendon reflex. He voids his urine and feces in bed. Pupils natural, left slightly dilated. No albumen in the urine. Gradually sank and died on Oct. 25th. Diagnosis: cerebritis and abscess of the anterior lobe of cerebrum.

P. M.—Body well nourished. Scalp congested. Dura mater very much congested, adherent to calvarium in front and torn in separation, also adherent to brain along both sides of falx; adherent at base of brain in front. On section, found a mass of sarcomatous matter as large as a lemon, in the left anterior lobe of cerebrum.

Dr. McCargow, who agreed with Dr. Mackelcan in the diagnosis, said there was no vomiting nor paralysis present in the case, but the patient was considerably emaciated. The early symptoms were of a neuralgic character.

Dr. Mackelcan described a case of a soldier who sought admission to the Hospital, and was supposed to be malingering, who dropped dead suddenly. The P. M. showed an abscess of the brain.

Drs. Stark and Ryall described cases in which a number of abscesses of the brain were found after death.

Dr. Macdonald related a case of a noted chess-player who died suddenly, and a number of abscesses were found in the cerebrum.

Dec. 1st, 1885.

Regular meeting, Dr. White, president, in the chair.

Dr. McConochie was elected a member of the

Society. Dr. Malloch introduced a case of multiple fracture, with nerve lesion. Patient, aged about 15, met with an accident on the 17th of August last by being drawn up between a belt and pulley. The left arm sustained a fracture of both radius and ulna; the pulse could be felt in the radial and ulnar arteries. Both bones of the right forearm were also fractured, and dislocated backwards at the elbow; no pulse could be felt at the wrist. The dislocation at the elbow was reduced, but on flexing the forearm, was produced again; a fracture of the coronoid process was suspected. An anterior and posterior pad was applied to the elbow after reduction, and secured by a figure-of-eight bandage, junk splints adjusted and the arms flexed and laid on pillows, the dressings were changed and readjusted as required. For some time passive motion was used. The left arm has made a complete recovery. The right arm has some loss of sensation in the distribution of the ulnar nerve, which is improving, and the elbow joint is gaining more power of motion. Pronation and supination are present to some extent.

Syme's amputation of the ankle joint. Patient was admitted to the Hospital Sept. 18th, under the care of Dr. A. Woolverton; age 53 years; occupation, blacksmith. Father dead, cause of death unknown. Mother was strong and healthy, lived to the age of 74 years. Had one brother who died at 40 years of age of kidney disease. One sister is alive and healthy so far as known. Had pleurisy in 1872 but completely recovered. Two years ago he had his left foot amputated, after being injured by a stone falling on it. Present trouble began last January with a pain in the heel, and some swelling. The foot improved about April, but got worse as the summer advanced. It was painted with tinct. iodi. and blistered, which relieved the pain but did not reduce the swelling. Had ague during the summer, during which the foot improved. Came into the hospital Sept. 18th, when he was unable to put his foot to the floor on account of the pain. Limb was put up in plaster which was removed about the 18th of Oct. It was again put up in plaster which gave him constant pain. On its removal the foot was found considerably swollen. It was then blistered and poulticed without relief. On the 22nd of Nov. fluctuation was evident just below the external malleolus. On the 25th a trocar was introduced, and considerable pus drawn off. Urine contained

nearly 50 % albumen, and also casts. Dr. McCargow exhibited specimens of bone taken from the case. Dr. Macdonald thought that by standing on one leg at his work, too much pressure was brought to bear on the ankle joint. It would be interesting to have the urine examined, to see whether or not any diminution in the quantity of the albumen has occurred. Dr. Ridley said the condition of the kidney may have followed the disease of the ankle joint. Dr. Ryall thought the kidney affection might have been merely a coincidence. Dr. Malloch thought the case was primarily one of kidney disease.

Dr. McCargow showed a specimen of tumor removed from a patient under Dr. Malloch's care at city hospital, admitted Nov. 27th, 1885. B. S. æt. 25. Father and mother alive and healthy. One aunt on the mother's side, and an uncle on the father's side had tumors. That of the uncle occurred on the neck. It was removed but is growing again. Patient has eight brothers and six sisters younger than himself, all strong and healthy. He never was sick until present trouble began three years ago, when he noticed a small lump on the outer side of the elbow. He continued to work, the tumor being painless and causing no trouble. It steadily increased in size for about eight months, when it reached the size of a hen's egg, and he had it removed. Six months after he noticed a tumor growing in the same place, which grew about nine or ten months, when he had it again removed. The second operation was performed in April, 1884. About Christmas he noticed the growth returning in the same place, since which time it has grown to about the size of the first. Present condition: on the outer side of the left elbow there is a large lobulated mass, part of which is ulcerated upon the surface; on the inner side of the arm is a smaller one not ulcerated. Nov. 28th the arm was amputated at the shoulder joint by flap operation, the outer flap being formed by the whole of the deltoid muscle. The glands in the axilla were swollen, and it is thought the disease will recur. Examination of the tumor with the microscope showed it to be encephaloid cancer.

Dr. Malloch also related a case which came under his notice in 1874. Patient was a man past 50. The tumor was situated between the hip and knee, and was the size of the head. Some thought it was a fatty tumor. The patient died in three or

four months from time of admission to hospital. The glands in the groin were not affected, but the pelvis was filled with secondary growths, also the lungs. \* Dr. Philp made some remarks on the previous case, and described the history before admission to the hospital.

### BRANT MEDICAL ASSOCIATION.

The usual quarterly meeting of the Brant County Medical Association was held at Brantford on the 1st of December. There was a good attendance of members present. The following officers were elected for the ensuing year. viz: Dr. Winskell, President; Dr. A. T. Henwood, Vice-President; Dr. Sutherland, Paris, Sec-Treasurer. The following new members were elected: Dr. Addison, St. George; Dr. Johnston, Burford; Dr. Sutherland, Paris; Dr. Mott, Paris.

Dr. Addison, St. George, read a paper upon Typhlytis and Dr. Burt gave the history of several recent surgical cases under his care.

Dr. Philip introduced the subject of the proposed amendments to the Ontario Medical Act advocating their adoption. The following resolution was moved by Dr. Addison, St. George, seconded by Dr. Johnson and carried—"That the proposed Amendments to the Ontario Medical Act approved at the last meeting of the Ontario Medical Council, and which will be submitted for approval to the Legislature at the next session, receive the cordial endorsement of this Association believing that such Amendments are just and necessary to the proper carrying out of the Act, and in the best interests of the Public and the profession alike.

A number of routine matters was disposed of, after which the Association adjourned to meet again in Brantford on the first Tuesday in March.

### Selected Articles.

#### SUPRAPUBIC LITHOTOMY, AND SUTURING THE BLADDER.

The *Med. News* reviews this interesting subject as follows:

"Within a year Sir Henry Thompson has operated for the removal of stone in the bladder by the suprapubic operation four times, and each time successfully. This measure of success has led him to

make public some strong expressions in regard to the merits of this form of lithotomy. After speaking of the capabilities of lithotritry, in the *Lancet*, for July 25, 1885, he says: "The problem thus left remaining for solution, is, what is the best cutting operation for hard calculi (urates and oxalates) which weigh from about two ounces and upwards, as well as for those not quite so large, which are so peculiar in form (as occasionally, but very rarely, happens) that the lithotrite fails to grasp, or retain them? I think there is no doubt about the answer—viz., that it is the suprapubic, and not the lateral position." And, again, "Finally, I think I am quite justified in believing that unless the operator has had a large experience of lithotritry (and there are not many of whom this can be affirmed) the high operation would generally be a safer proceeding than crushing for a calculus which is hard and much above an ounce in weight." In the same number of the *Lancet*, Professor Humphrey recalls attention to an operation of this sort which he did in 1848 successfully, and expresses his surprise that the suprapubic operation has not been more frequently performed.

These testimonials to the present appreciation of the operation of suprapubic lithotomy in England mark a distinct advance in public sentiment there, where hitherto this method has had but the faintest and most qualified acknowledgment, and, from Sir Henry Thompson himself, hitherto open contempt. Now, however, that so eminent and so conservative a surgeon has given his sanction to the suprapubic operation, its good may be said to have received the guinea's stamp, and to be current in all the Queen's dominions.

It is now about ten years since the merits of this, then almost abandoned method, were made the subject of thorough study in this country, and warmly championed upon theoretical grounds, as well as supported by analysis of a very large number of cases. At once it began to be practised with increased frequency in America; then it was taken up with new assurance in Austria; then in Holland; then in Germany, where it has always had some friends; then it had a genuine revival in France, and now it has secured the approval of the highest authority in regard to operations for stone in the bladder in Great Britain.

It would appear, therefore, that the time has passed for arguing about the worthiness of suprapubic lithotomy, as a general method; since the old prejudices have gone down so completely before the arguments used in its support, and the improvements introduced in its technique. It would seem that the future of stone operations remains with Bigelow's operation of litholapaxy and suprapubic lithotomy, and the only questions which have now a living interest with regard to the latter are those which pertain to the proper selection of cases and the manner of performing it. In regard to the

selection of cases it would not be easy to improve on what we have quoted above from Sir Henry Thompson. As to the technique, the plan of forcing the bladder up out of the pelvis by introducing a colpeurynter into the rectum and distending it with air or water, as was first done by Peterson, of Kiel, appears to be of great value. It may, perhaps, be responsible for the moderate hemorrhage reported in some recent cases, on account of the pressure it effects upon the venous plexus at the neck of the bladder; but it cannot be doubted that it has contributed much to the ease of performing the operation, and invited men to take it up who otherwise would not have done so.

In regard to after-treatment, the most important question concerns the employment or rejection of suturing the bladder.

This would appear to be no question at all if such brilliant results could be obtained regularly as have been affirmed in a considerable number of cases. Thus Bruns, who was the first surgeon to suture the bladder after lithotomy, secured uninterrupted union of the wound in his first two cases, both being little children. This was in 1857 and 1858. (These operations are often erroneously attributed Lotzbeck, who simply reported them. They were done in Brun's clinic. The bladder was sewed up during the Crimean war by Baudens, after the removal of a bullet by suprapubic cystotomy; recovery followed. Although this was not a lithotomy, it deserves to be mentioned, as the first case, so far as we know, in which an attempt was made to secure primary union of the bladder after an operation for the removal of a foreign body.) The variety of methods of closing the wound after suprapubic lithotomy is very great, but they may all be divided into those which close the bladder wall independently and those which close this and the wall of the abdomen together. The latter procedure has not been often carried out, although it has sometimes secured a brilliant result. The former has been done a considerable number of times, probably not much less than a hundred. The results have been so far from uniformly successful that it may be seriously questioned whether or not suturing the bladder be a method to be recommended. It will be admitted that this question can only be answered in the affirmative, if theory alone be considered. And, however imperfect may be the success as yet attained by it, the ideal operation of lithotomy must be held to include closing the wound, and securing primary union. This has been done a good many times, and can be done yet more.

But, in the present state of the technique of suprapubic lithotomy, we think it safe to qualify our statement that suturing the bladder is to be regarded as essential to the ideal operation. The ideal operation implies conditions suited to it, and, without going into details, we think it will be ac-

knowledge that such conditions are not found in a considerable number of cases of stone operations. Suturing the bladder is manifestly out of place in cases in which the condition of the bladder is such as to preclude the idea that it can heal up by primary union, or in cases in which free drainage is manifestly a desideratum. Again, it is not suited to cases in which the size, shape or position of the bladder, or of the neighboring parts is such as to make the procedure very difficult, or to prevent its being accurately—we may say perfectly—carried out. In these cases, certainly, it is far better to treat the wound after suprapubic lithotomy like the wound of perineal lithotomy—that is, to leave it open, and to secure free drainage through it.

For cases in which suturing the bladder is suitable, Znamenski recently proposed to bevel off the internal mucous edges of the wound, because he believed they got caught and turned in between the united edges when the sutures were tightened, and so prevented union. And Vincent has still more recently suggested beveling off the external edges of the wound in the bladder, so that, when the stitches are drawn upon, a larger fresh surface shall be brought together, and the chances of union thereby be increased. This idea, which he never put into practice, has been taken up and carried out by Géza, of Antal, who reports in *Langenbeck's Archiv*, Bd. xxxii. 2 Heft, 1885, under the title "Eine Modificirte Sectio alta," a case of lithotomy and a case of removal of a morbid growth, in both of which he secured primary union by suturing the bladder in this way. The first patient was dismissed cured in twelve days, but was really fit to be dismissed in nine days. The second patient made an equally prompt recovery.

The plan of Dr. Géza consists in exposing the bladder by the usual method, after distention of the bladder and the rectum, and then in freshening an elliptical space a little longer than the proposed incision in the bladder and from one to one and a half centimetres in width. This freshening is carried so deep at the line of the proposed incision that there is little left but the mucous membrane of the bladder, which is afterwards incised and the stone removed. The sutures he uses are of silk, rendered antiseptic with corrosive sublimate; cat-gut, he believes, gives way too soon. Each stitch is to be applied so as to include all of the bladder wall, except the mucosa. The wound in Dr. Géza's case was covered with Lister's dressing, and a soft catheter left in the urethra.

It is worth while to call attention to this proposition of Dr. Géza, because it is ingenious, and, reasoning from the analogies of operations for vesico-vaginal fistula, its execution may be expected to make the sutures much more reliable than when they were applied in a simpler fashion. It is to be noted, too, that this is a very different thing from the Lambert suture, which is very good

in its way, but which seems to offer less hope of prompt union from the apposition of two serous surfaces than this one does from its apposition of two fresh-cut surfaces. In addition to this, the fact that it has already proved so successful in the hands of its proposer is strong recommendation to its further employment.

No study of the plans of suturing the bladder after suprapubic lithotomy would be complete which omitted consideration of an ingenious method used in 1876 by Dr. Starr, of Georgia, his patient recovering in sixteen days. This case was first reported by Dr. Dulles, in an article on suprapubic lithotomy in the *American Journal of the Medical Sciences* for July, 1877, and again, by the operator in the *Atlanta Medical and Surgical Journal* for December, 1877. The suture used was of silver wire; it was interrupted; each stitch was passed into the abdominal wall at one side of the wound and made to include a small portion of the outer layers of the bladder wall; it then passed across the incision and included a similar small portion of the outer layers of the bladder wall on the other side; it then passed up through the abdominal wall to the surface. When drawn tight it slightly inverted the bladder walls and brought the edges of the abdominal incision close together. It is easy to see that this form of suture must tend to prevent burrowing of discharges between the bladder and parietes of the abdomen, while it gives a good hold to the stitches which close the bladder itself.

The success obtained by Dr. Starr in its use should encourage others to imitate him. Certainly no better result could be asked for than he obtained.

We sincerely hope that American surgeons will not be backward in contributing their share to the solution of the problem as to the best way to conduct this operation. Its present standing is largely due to their courage in defending and practising it at a time when it was held in much lower esteem than it is now; and we believe the genius in dealing with practical questions in medicine and surgery, which has always been conceded to them, cannot fail to prove of great value if applied to the question of the best method of treating the wound after suprapubic lithotomy."

### THE PHYSIOGNOMY OF DISEASE.

Dr. J. B. Walker gave the following clinic on this subject in the Philadelphia Hospital.—*Med. and Surg. Reporter*:

Just as we are able to recognize the features of our intimate friend and call him by name before he makes his identity known to us, so with the outward features of disease; there is a physiognomy, a feature or external expression of internal disease that is more or less characteristic. But,

just as we find it difficult to so accurately describe the features of a friend to a third party that he can recognize him, so is it with the description of this physiognomy of disease. But, let the third person once see our friend, and he will thereafter recognize him; so it is with disease.

*Malarial Fevers.*—When a patient is pale and anæmic, the mucous surfaces pallid, conjunctiva pale, tongue pale, lips blanched and but slightly colored, we may suspect some malarial cachexia. In this connection, Dr. Walker makes a strong argument for the use of capsicum in malarial fevers; he thinks it is not ordered nearly enough. It seems to aid and increase the power of quinine and prevents it from deranging the stomach.

R. Quinine sulph. . . . . gr. c.  
Oleo resin. capsici. . . . . gr. xii.  
M. and div. in pil. No. 1.  
S.—Two pills every four hours.

\* *Bright's Disease.* In this disease, while there is no absolute certainty in the appearances presented in the face, yet the physiognomy is sufficiently characteristic to cause us to suspect the disease when certain peculiarities are observed. When, while there may not be marked œdema, there is yet sufficient puffiness of the face to cloud or displace the ordinary lines: when the blood vessels are distended, showing us red lines in the cheeks and nose, when there is sagging of the cheeks, a fullness of the jowls, and a peculiar earthy, pearly pallor, we have reason to look for Bright's disease. There is often noted a peculiarity of gait, consisting of a difficulty in keeping the equilibrium, due, most likely, to the influence on the brain of an imperfectly depurated blood, owing to the faulty action of the kidney.

From a distance, the face may sometimes present a ruddy hue, but closer examination will demonstrate this to be due to dilated blood-vessels and ecchymotic spots. The superficial arteries and veins of the head and neck are tortuous and dilated, being sometimes visible from a distance. The arcus senilis is another evidence often found. Atheroma of arteries and arcus senilis are surface indications of granular nephritis. But such appearances may be present when there is no Bright's disease, as, for example, the result of syphilitic infection or chronic alcoholism. œdema (general) or ascites rarely occur in a marked form in granular or interstitial nephritis, but it may occur when this form of the disease is complicated with an attack of *catarrhal* nephritis, to which form dropsy peculiarly belongs; it may also occur in the waxy form, but is not so common there.

*Carcinoma.*—Dr. W. calls especial attention to a peculiar glistening sheen of the surface (not unlike moonlight on the water) as very characteristic of carcinoma. It is not always present, but when it is observed it is a very strong sign; indeed, Dr. W. has only seen it once where the autopsy has

failed to reveal cancer, and in that case he is not certain that the disease may not have existed in some portion of the body not examined. The illustrative case had an expression of suffering, while the skin was much jaundiced. This glistening sheen is scale-like, so to speak; not scales that you can scrape off, but the glistening surface is marked by lines that do not glisten. It is most frequently present on the surface of the abdomen.

*Typhoid Fever.*—There is flushing of the cheeks (no sordes in the illustrative case, because the nursing is good); apathy is marked, so much so that flies walk unnoticed over the face; the eyes are half closed, the mouth open, and he breathes through it.

This being a typical case of typhoid, Dr. W. made a few remarks on the disease. When the morning temperature is below  $102^{\circ}$  and the evening temperature not above  $104^{\circ}$ , it is a satisfactory condition. While the eruption may occur in tubercular lesions, yet it does so so rarely that they may be considered characteristic of typhoid. They are circumscribed, elevated, and rosy; rarely punctate, but occasionally become vesicular. They will disappear on pressure and after death. They generally appear on the trunk, but rarely on the extremities, though he has seen them on the hands. In order to be sure about the disappearance on pressure, we should place a finger on either side and stretch the vessel, for if we simply press on the spot and remove the pressure, the pressed-out blood will flow back so rapidly that we cannot be sure whether it has disappeared or not.

## DANGERS OF ANTITHERMIC REMEDIES.

In a recent therapeutical conference, Dr. Dujardin-Beaumetz discusses resorcline, kairine, thalline, and antipyrine, and advises caution in their use, of the first three agents especially, from their active toxic effects. After referring to the eminently antiputrefying and antifermentive properties of resorcline, he states that he had used it in pyrexia without obvious effects, probably on account of the smallness of the dose. He finally abandoned it altogether in the treatment of rheumatism and typhoid fever, not so much on account of its want of power as because he observed toxic symptoms. Resorcline is not only an irritant, it is also a toxic agent; and in his experiments upon dogs it was determined that a dose of thirty centigrammes per kilo of weight of the animal produced convulsive phenomena, and death was caused when the proportionate dose was increased to ninety centigrammes. After death, visceral congestions were discovered, and especially very intense pulmonary engorgement, as in animals poisoned by carbolic acid. Man is even more susceptible to the effects of resorcline than dogs. Munel reports a case in

which a single dose of three and a half grammes (fifty-three grains) rapidly induced a condition of great gravity, which, however, was finally overcome.

Dr. Beaumetz says, "While recognizing resorcline as less toxic than phenic acid, I conclude that it is a dangerous antithermic agent, for I found in my typhoid patients treated with resorcline the same depression of forces, the same adynamia, the same pulmonary congestion, which I had found in those to whom I had administered phenic acid. I have therefore abandoned this medication, and I believe that, even in Germany, resorcline is not much employed internally, but it remains, on the contrary, a very valuable remedy for external use in the treatment of unhealthy wounds."

Kairine is an antithermic acting by diminishing the respiratory power of the blood and destroying hæmoglobin. The recent researches of Brouardel and Paul Loyer confirm this view, and show that thalline and kairine exert the same destructive effect upon hæmoglobin. Moreover, contrary to the usual action of antithermic agents, kairine and thalline have no influence whatever upon fermentations. "Kairine should therefore be rejected from therapeutics; it is a dangerous drug, since it only produces antithermic effects by destroying the hæmoglobin and profoundly altering the blood, circumstances which should be avoided in the infectious febrile diseases."

Antipyrine is less toxic than either resorcline or carbolic acid. While it takes a gramme of resorcline per kilo to kill a rabbit, it takes 1.60 grammes per kilogramme of antipyrine. The toxic effect, moreover, is almost the same; it produces tetanic and paralytic symptoms analogous to those caused by strychnine-poisoning. It cannot be doubted, therefore, that antipyrine acts upon the cerebro-spinal axis, and it is probable that it lowers the temperature by modifying the nervous heat-centres. Contrary to kairine, antipyrine does not appear to change the liquor sanguinis, and particularly the hæmoglobin. It has also hæmostatic properties which Hænoch declares superior to those of ergotine and of chloride of iron. (This is worth bearing in mind in treating hæmoptysis.) Antipyrine diminishes the urinary secretion, but increases the action of the glands of the skin, which renders it inconvenient to use it in cases of tuberculosis. Like the phenols and oxyphenols, antipyrine is an antiferment. The study of recent antithermics shows that the effects of these new agents vary with the nature of the fever; a temperature of  $104^{\circ}$  in a phthisical patient will be lowered by fifty centigrammes of antipyrine, while in a typhoid case it might be without effect.—*Bull de Thérapeutique*, August 30.

WHY DOCTORS' BILLS ARE SOMETIMES UNPAID.  
—One reason why bills of physicians are unpaid is

negligence in collecting them. This is especially the case when mechanics and other persons of limited incomes are treated. Despite the temptations which constantly beset the honest clerk, and others of his ilk, to dodge pecuniary responsibility through the many avenues of medical charity, there is at first an inclination to pay the doctor, if reasonable opportunities are offered for so doing. Too often, however, the medical attendant, actuated by false pride on one hand and an eagerness for business on the other, allows the money question to be in abeyance until the bill becomes relatively of startling size. The clerk and mechanic, as a rule, are persons who are accustomed to pay small bills, and to do so frequently. They themselves are paid weekly, and if provident, calculate their expenditures regarding board, room rent, clothes, and family necessities to a nicety. They belong to the pay-as-you-go class, although their business is on a small scale. The trouble, however, is that the family physician generally places himself above that scale and suffers accordingly. If his bills were presented even weekly he might have a chance to be served with the same consideration as the grocer, the butcher, and the baker. But he believes it unprofessional to be pecuniarily concerned, and the consequence is that the patient gets into the habit of believing that the doctor's bills are the hardest of all to pay. It does not appear to him that there is so much necessity about it. The doctor by his indifferent manner gives him to understand that there is no pressing necessity about it, and the patient acts accordingly. The bill consequently runs on until in the course of weeks and months of attendance it amounts to possibly fifty dollars or more. The patient paying week by week for what he is taught to believe by the ordinary tradesmen are his cash necessities has nothing left for the forced luxury of medical services, the large bill becoming a mill stone about his neck. If he reasons with himself he must acknowledge that the dues are just, but how to get blood out of a stone is a dreadfully perplexing problem with him. He may possibly commence to economize, in order to offset what he coaxes himself to believe is an infliction, for few men receive a doctor's bill joyously. But pressing necessities for ready cash in his household present themselves and offset his best intentions. The medical attendant in the meantime sends his collector. The latter always arrives at an inopportune moment. He is generally as much out of place under the circumstances as is the skeleton at the feast. He is sometimes not even treated as a friend who comes to help the impecunious sufferer out of difficulties. His purer motives are misinterpreted, and his smiling overtures are received with studied coolness. If he talks of discharging obligations to the doctor, the good wife, who was once sick, is now well enough to take her part. The visits were

made oftener than was necessary, at least so she now thinks, and the charges were exorbitant; at all events the doctor must be patient until they get the money. But alas! the medical attendant waits in vain, even long after the enterprising collector has given up the case. Little Johnny is taken sick in due time. The doctor is sent for and will not come. The family are now righteously angry. Then the retaliatory spirit asserts itself. What might have been treasure on the earth for the expectant creditor, has been transferred to an account that can only be collected hereafter. Johnny's father feels indignant and independent. Hereafter he will do his doctor business on cash principles, and he takes Johnny to the Out-Patient Department of the New York Hospital, pays his dollar and takes his choice. His pretended poverty is counterbalanced by his respectability, and he reproaches himself for not taking advantage of such opportunities before. The only way, under the circumstances, for the doctor to get such patients back again, is to secure an appointment in the Department, and be privileged to treat them for nothing.—*Med. Record.*

NEW RESEARCHES UPON BRIGHT'S DISEASE.—Prof. Semmola deduces the following conclusions (*La Med. Contemp.*) from the results of his latest experimental and clinical researches upon Bright's disease:

1. Albumen can traverse the renal tissue without any previous alteration in the histological elements of the kidney, and without leaving any trace of its passage.

2. If the passage of albumen be persistent, the first effect is hyperemia with intraglomerular and intratubular hemorrhage, and the capsule is distended in a mass after boiling, and sometimes is simply raised and separated from the glomerulus by an empty space. There is also observed considerable migration of leucocytes without any alteration of the epithelium. The urine contains hyaline cylinders. These are the first results of an inflammatory action in relation with the functional activity of the kidney.

3. If the functional process persists beyond even eight or ten days, especially with the injection of albumen in the proportion of one gram for every thousand grams of the animal's weight, the invading process is attended by a mild inflammatory action, in addition to a turbid swelling of the epithelium of the tubules, fatty degeneration, and thickening of the intratubular connective tissue.

This proves that the functional activity which the kidney must sustain in the gradual and prolonged elimination of unassimilable albumen, is apt to provoke successively in different parts of the organ an inflammatory process, which, commencing in simple hyperemia, may result finally in the establishment of interstitial nephritis. Prof. Sem-



mola is convinced by repeating the experiments and injecting very minute quantities of albumen, in order to have the experiments well under control and preserve the life of the dog for seven or eight months, that they will result in producing the last phases of the large white kidney—that is to say, the atrophic kidney.

4. The histological alterations in the kidney persist for some time after the injection of the albumen without producing a continuation of the albuminuria.

5. Along with the elimination of albumen with the urine is also observed albuminocholia: that is to say, the elimination of a certain quantity of albumen with the bile.

In relation with the above experiments, Prof. Semmola proposes to continue his researches on the pathology of Bright's disease with the following experiments to determine:

1. The comparative influence upon renal elimination produced by the injection of albuminose, which is presumably more assimilable, such as serum of blood, albumino-peptones, white of egg and milk.

2. The influence of albuminous injections upon the crasis of the blood, and upon the elimination of a quantity of albumen greater than that injected.

3. The influence of albumen injections upon degree of activity in the combustion of nitrogenous matters and upon the production of urea.

4. The influence of albuminose injections upon the dyscrasic condition of the blood, and their relations with the production of anasarca.—*Lon. Med. News.*

**A VALUABLE REMEDY FOR HEADACHE.** The *Phys. and Surg. Investigator* calls attention to the following treatment for many kinds of headache.

"We lay no claims to originality, nor do we know who the originator was, but having used it for a year or more, and in many cases with remarkable results, we feel disposed to give it our indorsement, and desire to make it more generally known. The remedy is nothing more or less than a solution of the bisulphide of carbon. A wide-mouthed, glass stoppered bottle is half-filled with cotton or fine sponge and upon this two or three drams of the solution are poured. When occasion for its use occurs the mouth of the bottle is to be applied to the temple or as near as possible to the seat of pain, so closely that none of the volatile vapor may escape, and retained there four or five minutes or longer. For a minute or so nothing is felt, then comes a sense of tingling, which in a few minutes—three or four usually—becomes rather severe, but which subsides almost immediately if the bottle be removed, and any redness of the skin that may occur will also quickly subside. It may be re-applied, if necessary, several times in

the day, and it generally acts like magic, giving immediate relief.

We believe this was the basis of a once popular nostrum. The class of headache to which it seems especially adapted is that which may be grouped under the broad term of "nervous." Thus neuralgic, periodic and hysterical headaches are almost invariably relieved by it. True, the relief of a mere symptom is quite another thing from the removal of its cause, yet no one who has seen the distress and even agony caused by severe and frequently recurring headache (and who has not?) but will rejoice to be able to afford relief in so prompt and simple a manner; besides it is sure to secure the hearty gratitude of the patient if he has suffered long. As to the *modus operandi* we have nothing more definite than a theory to offer, and that is that the vapor being absorbed through the skin produces a sedative effect upon the superficial nerves of the part to which it is applied. We know by experiment that its influence is not due to its power as a counter-irritant. We however know that it does act, and if we do not clearly see in what way it acts, that is no more than can be said of several other remedies which are firmly established in professional favor and confidence."

**THE NATURE AND TREATMENT OF OZÆNA.**—At the International Medical Congress held in London three years ago M. Læwenberg, of Paris, referred, in the discussion on ozæna, to the invariable presence in the nasal mucus of those affected with ozæna of a special microbe said to be unique and characteristic. It was a micrococcus of very large size, which always occurred in pairs and chains, and was for the most part motionless. In 1878, M. B. Fraenkel affirmed that the mucus secreted in ozæna consisted for the greater part of pus-corpuscles plentifully strewn with micrococci. The only writer besides Læwenberg who has made extensive researches on the micro-organisms of ozæna is M. E. Fraenkel, and, what is not so very unusual in these matters, the observers differ considerably from one another in their respective descriptions of the micro-organisms to be found in cases of ozæna. But Læwenberg explains the difference by pointing out the divergence in the methods employed to detect the micro-organisms. He examines simply the masses that are discharged from the nose in ozæna, whilst Fraenkel investigated the secretion that soaked into the plugs of cotton-wool with which he treated his cases of ozæna. Læwenberg, in a pamphlet recently published, believes that ozæna is a specific disease due to the presence and growth of his micrococcus: it is also regarded as a contagious affection. Energetic parasitocidal or antiseptic treatment is the necessary sequence of the above conclusions. He employs a nasal douche made with a weak solution of corrosive sublimate, of which the strength to commence with

should be 1 part of the sublimate to 10,000 parts of water ; it should gradually be made stronger as the patient becomes accustomed to its use. Insufflations of impalpable boric acid powder are also recommended. Læwenberg claims to have had a remarkable success in his treatment of "rhinitis chronica atrophicans fetida."—*Lancet*.

**INFLUENCE OF CIMICIFUGA UPON PARTURITION.**—After a *résumé* of the medical history of the drug, Dr. Knox (Chicago Gynaecological Society), gave the results of his clinical observations in one hundred and sixty cases of labor,—fifty-seven primiparae, ninety-three multiparae—in which black cohosh had been exhibited. The average duration of the first and second stages of labor, in normal cases, in primiparae, was seventeen and three hours respectively. Under the influence of black cohosh, the duration of the first and second stages of labor, in the fifty-seven cases observed, was six and one-quarter and one and three-quarters hours respectively. The average duration of the first and second stages, in normal cases, in multiparae, was twelve and one hours respectively. Under the influence of black cohosh, in the ninety-three cases observed, the average duration of the first and second stages was three hours and twenty-seven minutes respectively.

From these clinical observations Dr. Knox drew the following conclusions :

1. Cimicifuga has a positive sedative effect upon the parturient woman, quieting reflex irritability, nausea, pruritus, and insomnia, so common in the last six weeks of pregnancy ; it always renders them less distressing, and they often disappear under its administration.

2. Cimicifuga has a positive antispasmodic effect upon the parturient woman. The neuralgic cramps and irregular pains of the first stage of labor are ameliorated, and often altogether abolished. In fact during the first indiscriminate use of the drug in all cases, I had the mortification, with a few women, of terminating the labor so precipitately, and without prodromic symptoms, as to be unable to reach the bedside before the birth.

3. Cimicifuga relaxes uterine muscular fibre, and the soft part of the parturient canal, by controlling muscular irritability, thus facilitating labor and diminishing risks of laceration.

4. Cimicifuga increases the energy and rhythm of the pains in the second stage of labor.

5. It is my belief that cimicifuga, like ergot, maintains a better contraction of the uterus after delivery.

It is his habit, however, to administer fifteen to thirty minims of the fluid extract of ergot after the birth of the foetal head, and he has had but few opportunities of testing this effect of the cohosh. His method of administration has been to give fifteen minims of the fluid extract of cim-

cifuga in compound syrup of sarsaparilla each night for four weeks before the expected confinement. One fluid ounce of the fluid extract of cimicifuga to three fluid ounces of compound syrup of sarsaparilla—dose, one teaspoonful—makes just the required quantity.—*Jour. Am. Med. Ass.*

**RECOVERY FROM MALIGNANT PUSTULE.**—Dr. W. E. Buck records this case (*Brit. Med. Jour.*)—Mr. F—, aged thirty one, a veterinary surgeon, experienced on October 6th a stinging sensation at the back of the right wrist. A small bleb was formed, which he scratched off, and there was some tenderness of the elbow and armpit. He had a slight rigor. On October 8th he was seen by Dr. Meadows, who prescribed some salicylate of soda and tincture of aconite, in frequent doses, as his temperature was 104°, and the rigors continued almost the whole of the day. A black eschar began to form on the afternoon of the 8th, and on the 9th it became about the size of a sixpence ; its base was red and oedematous, and surrounded by some vesicles in a circular shape. The temperature was nearly 104° ; the patient felt cold, and the tongue was foul. I visited the case with Dr. Meadows, and we injected pure carbolic acid under the eschar, using an ordinary hypodermic syringe. Unfortunately we could only introduce a small quantity, as it oozed out in the withdrawal of the syringe, and with it a serous looking fluid. I dried some of this fluid on a cover-glass, stained it with methyl-violet, and found the well-known bacilli of anthrax. We prescribed large and frequent doses of soda-hyposulphite, and ordered also a large quantity of meat. Under this treatment he rapidly improved. On October 12th we again injected carbolic acid. The temperature came down, and, as the patient said he felt all right, the hyposulphite of soda was reduced to three times a day. The eschar did not finally separate for nearly six weeks, and the ulcer then soon healed. I believe that the main remedy in this case was the injection of pure carbolic acid, a mode of treatment which does not seem very painful. There was a clear history of the disease, which was contracted exactly twelve days before its first appearance, Mr. F— having examined the flesh of an animal that had died from anthrax.

**EXCISION OF THE HIP.** Dr. Wm. Alexander, of Liverpool, closes an interesting paper on excision of the hip, in the *Med. and Chirurg. Journal*, as follows :

1. That hip disease should, in the earlier stages, be treated by that absolute and perfect rest obtained by means of Thomas' splint.

2. That this treatment, thoroughly and persistently carried out for a long period, will cure a large percentage of joint diseases.

3. Unfortunately, this treatment cannot and is not persistently carried out amongst the poor.

4. Many of these patients could be saved by excising the joint when a decided second stage of hip disease has been reached. Excision is best performed by severing the femur above the trochanter, clearing out the acetabulum, and maintaining the opposing bones so far apart that their surfaces can resume a healthy condition and the aperture be filled up with fibrous tissue. By this means an excellent false joint is formed, or, if the adhesions become too firm, a good stiff joint.

5. That the advent of the stage of this disease suitable for excision is indicated by repeated formations of abscesses around the joints.

6. That when the supra-trochanteric mode of excision cannot be performed with any chance of success, then the alternative is either continued expectancy or amputation.

7. That it is a great mistake to imagine that all softened bone or infiltrated tissue should be cleared away by the operator. All he has got to do is to clear a space, where the operations of nature, in dealing with diseased or disabled tissues, can be carried out as easily and expeditiously as possible. The operator should remove all manifestly dead tissue, but the doubtful should be left alone to be dealt with by nature.

**THE BLOOD IN TYPHOID FEVER.**—The systematic examination of the blood during and after acute specific fevers would, we believe, yield results of very high importance, and we recommend such a subject of study to our younger scientists. The investigations should be made from many points of view. Thus, the corpuscular richness, the relative quantity of hæmoglobin contained in each red disc, the state of the fluid portion, both as to its quality and quantity, should each receive consideration. Dr. Frederick Henry, of Philadelphia, has made a partial investigation of the blood during and after typhoid fever. He finds that the number of red discs is about the normal during the fever, but is very much less than normal after the fever. This apparently paradoxical observation is explained on the ground that during the pyrexia the fluid portion of the blood is diminished in quantity, causing a relative plethora. After the fever has subsided, the "water" of the blood again becomes normal, and the red corpuscles assume their proper portion in relation to it. Thus we have a genuine anæmia, which really existed, though masked, during the fever. Dr. Henry is of opinion that patients suffering from typhoid fever should take water as a medicine, as well as to relieve thirst. Similar views have been expressed by other physicians. *Lancet*.

**CANNABIS INDICA AS A NARCOTIC.**—H. Lewis Jones, M. B., Cantab., gives the following in the *London Practitioner*:

This drug has proved of great use in a number

of cases where I have desired to produce sleep, especially where sleeplessness was accompanied by delirium. In the delirium of typhoid fever and erysipelas, and in delirium tremens, it is most valuable, a few doses being sufficient to give refreshing sleep. It is important to give the drug in sufficiently large doses. Two or three grains of the extract can be taken in the form of pill every four or every six hours; frequently the first dose is sufficient. I now prescribe cannabis indica as the routine treatment in all cases of delirium tremens coming under my care, whether simple or complicating injury or disease.

In only one case has there been complaint of hallucinations. It had been ordered for a case of typhoid fever with much sleeplessness, in an excitable young woman; after two or three doses she asked that the drug might be discontinued, saying that it caused her to see visions of beautiful gardens and the like. All the other patients have been hospital cases. It is possible that among educated people mental disturbance would be more frequent. I have heard of one case where two grains of the extract were said to have made a woman temporarily quite mad. Personally doses of the extract of Indian hemp, up to four grains, produce a mild narcotic effect, the only abnormal sensations noticed being numbness of the extremities and slight mental confusion.

**REMEDIES FOR SKIN DISEASES IN THE FORM OF SPRAY.**—Dr. Hardaway highly recommends spray as a vehicle in the treatment of affections of the skin. His usual habit is to prescribe a solution of definite strength from which the bottle of an ordinary handball apparatus is filled, and the patient is then directed to throw the fine spray on the parts affected. Any substance that is "sprayable," either in its liquid form (diluted or pure) or in a state of solution, may thus be employed,—e. g., carbolic acid, sulphate of zinc, lotions of grindelia robusta, thymol, liq. picis alkalinus, and fluid cosmoline (medicated or not). In the case of the fluid cosmoline, the tube of the atomizer should be large. The spray finds its greatest range of usefulness in diseases affecting large areas and in that class of disorders accompanied by itching and a more or less unbroken cuticle,—viz., pruritus, urticaria, papular eczema, and the like. In generalized pruritus he had had good results from spraying on a lotion of the following sort: carbolic acid, three to four drachms; glycerine, one ounce; and water, a pint. After the bottle of the atomizer had been filled, he sometimes directs the patient to add from five to ten drops of the oil of peppermint. The atomizer-bottle should be thoroughly shaken before the bulb is compressed, in order to diffuse the peppermint through the mixture, as otherwise it would merely float on top. In many instances the spray is far superior to mopping on lotions with a sponge

or rag, being neater and less troublesome, getting the remedy more evenly and uniformly applied over the surface, and usually giving more speedy relief.—*Jour. of Cut. and Ven. Dis.*

**THE TREATMENT OF PUERPERAL ECLAMPSIA.**—M. Chambert, in his *Thèse pour le Doctorat en Médecine*, Paris, 1884, (*Medical Chronicle*), gives an account of eight women attacked with puerperal convulsions, one of whom died. The treatment pursued was uniform, and the same as recommended at the conclusion of his thesis. The value of his thesis consists in a concise statement of the treatment which is at present generally accepted in Paris as the best, although violently opposed by Professor Pajot and other eminent obstetricians.

M. Chambert's conclusions are :

1. A woman presenting the following symptoms, albuminous urine, œdema of the lower limbs, headache, troubles of vision, etc., should be placed on an "absolute milk diet."

2. After convulsions have occurred the bowels should be cleared out, and then an injection should immediately be given containing six or eight grammes (90 to 120 grains) of chloral, according to the intensity of the convulsions. If the temperature rises this should be repeated after two hours, and if the convulsions still persist, the patient should inhale chloroform. The usual formula for the injection is—new milk  $\bar{5}$  iij, yolk of one egg, chloral hydrate grs. 90.

In a plethoric patient, with symptoms of congestion, it is permissible to bleed to an amount not exceeding 16 ounces.

3. In every case the termination of labor should be hastened, provided dilatation of the os is complete, the forceps being applied or version employed if there is the least delay in the expulsive stage of labor.

The milk regimen should be continued till albuminuria has completely disappeared, and if, after labor is over, convulsions threaten or actually occur, a draught of 90 to 120 grains of chloral may be expected to arrest the attacks. Milk regimen, chloral and chloroform are the most powerful means of modifying the unknown cause, which produces puerperal eclampsia.—*Am. M-d. Digest.*

**THE TREATMENT OF GANGRENOUS INTESTINE IN STRANGULATED HERNIA.**—In a paper having the above title, W. Mitchell Banks, F.R.C.S., (*London Medical Times*), sums up the following conclusions:

1. That when gangrenous gut is discovered in a hernial sac, no attempt whatever should be made to divide the stricture.

2. That practical experience is required to determine the expediency of drawing down into the hernial opening a fresh piece of bowel.

3. That the cases appropriate for resection of the

gut must be very few, requiring, as it does, that the patient should be young and vigorous, with abundant reparative power; that the hernial sac should not be full of putrid pus or evacuations from a perforated bowel; and that the operation should be done in daylight, and with competent assistance and antiseptic precautions. So far the statistics of resection of gangrenous bowel show a mortality of 52 per cent., whereas by making an artificial anus all the patient's immediately dangerous symptoms are relieved, while he has a chance of subsequent cure (a) by spontaneous closure of the aperture; (b) by the use of the enterotome or the rubber tube; and (c) by the employment of resection at a later stage, the statistics of which show a mortality of only 38 per cent.

4. That in resecting a bowel it is not necessary to have an apparatus to distend it, and that while the fingers of an able assistant will generally serve to control the divided ends, it may be necessary to use some simple clamping instrument having parallel blades and covered with rubber.—*M-d. Med. Jour.*

**SCHULTZ'S METHOD OF RESUSCITATING THE NEW BORN CHILD.**—At the last annual meeting of the Medical and Chirurgical Faculty of Maryland, Dr. Neale (*Med. Record*), illustrated Schultz's method of resuscitating the new born child in case of asphyxia. The child is held by the shoulders, the thumbs resting upon the thorax, the child's head toward the operator, and its anterior surface to the front; it is then swung upwards so that its feet perform a revolution, and lie between the head and the operator's body, the trunk being then in a state of forced flexion. The original position is then resumed by a reverse movement, and the repetition of these movements constitutes the method. Dr. Neale regarded it as more effective than Marshall Hall's or Sylvester's, and related a case in which resuscitation had been secured after ten minutes, the measures mentioned and all others having been tried in vain.

**NEVER OVERLOOK AN OVER-DISTENDED BLADDER.**—A writer reproduces the histories of several cases of retention of urine, in which the over-distended bladder was mistaken for abdominal tumor. In the comments following, a case is related in which the writer was called in consultation to examine a woman recently confined, in whom incontinence of urine had led to the suspicion of vesicovaginal fistula. The withdrawal of three quarts of offensive urine cleared up the diagnosis.

The case last related recalls very vividly an incident in the lying-in ward of the Charity Hospital, which occurred some years ago, in the days of Prof. Frank Hawthorn. A two-hundred-pound negro woman recently confined, was "passing her water in bed" to the satisfaction of the nurse and

the resident student. But to the professor, on his morning visit, the words in quotation were ominous. A gum-elastic catheter was introduced in the presence of the medical class, and to the present writer, more especially, it did seem that the flow of urine would never cease.—*Id. Med. Jour.*

**FROSTBITTEN FINGERS AND TOES.**—Dr. Lapatin, in the *Proceedings of the Caucasian Medical Society*, advises that fingers and toes which have been slightly frostbitten, and which subsequently suffer from burning, itching, and pricking sensations, should be painted, at first once, and afterwards twice a day, with a mixture of dilute nitric acid and peppermint water in equal proportions. After this application has been made for three or four days, the skin becomes darkened and the epidermis is shed, healthy skin appearing under it. The cure is effected in from ten to fourteen days. The author has found this plan very effectual amongst soldiers, who were unable to wear their boots, in consequence of having had frozen feet. They were, in this way, soon rendered capable of returning to duty.—*British Med. Jour.*, Sept. 5th.

The *Denver Medical Times* puts the matter of abortion in the following forcible anecdote: A woman carrying her 12-months' old child consulted a doctor to have an abortion performed, giving as her reason that she could take care of one child, but not of two. "So you want one of them destroyed?" suggested the doctor. "Yes," replied the mother, with lowered voice and dropping her head. The doctor seized a hatchet and rushed at the child in her arms as if to brain it. "In Heaven's name," shrieked the woman. "Do you mean to murder my darling?" "Madam," replied the doctor, "you want one of your children killed. I prefer to kill the one in your arms, for in attempting to kill the other I might possibly also kill you, and thus be a double murderer."

**HYDRASTIS IN UTERINE DISEASES.**—Dr. Shives, rizyeff writes to the *Moscow Medical Review* of the satisfactory results he has obtained by the use of *hydrastis canadensis* in uterine hæmorrhages of various kinds due to hyperæmic conditions of the organ. He gives 20 drops of the fluid extract. The same remedy is, he says, useful in cases where the uterus is enlarged with ulcerated mucous membrane, giving off a copious exudation. Also in cases of dyspepsia due to disorder of the female sexual organs. The drug acts, according to Shatz and Mendes de Leon, on the vessels of the uterus, not, like *secale cornutum*, on the muscular strictures; but it is at present doubtful to which of the three alkaloids—*hydrastin*, *berberin*, and another which is not yet known—the hæmostatic action is due. *Lancet*.

**DELIRIUM IN BRIGHT'S DISEASE.**—On the occasion of a case of delirium in Bright's disease being read at the Paris Hospital Medical Society, Dr. Quinquaud observed (*Gazette hebdomadaire*, August 28th), that in clinical practice great difficulty often exists in determining whether this symptom arises from primary cerebral disease, or is an uræmic manifestation. But there is a very simple means of determining the point; for if analysis of blood obtained by cupping reveals an excess of urea, we have to do with uræmic accidents. This is almost a constant rule whatever may be the pathogeny of the uræmia. There is no proof that excess of urea in the blood is the proximate cause of the morbid manifestation, but when uræmia exists, this excess is almost always met with.—*London Med. Times*, Sept. 5.

**SUBINVOLUTION OF THE UTERUS.**—Dr. F. Ellingwood (Chicago) considers fluid extract of ergot and bromide of potassium as specifics in subinvolution. Regarding the benefit to be obtained from electricity we quote as follows: "Electricity is a most powerful adjuvant, and if used in the form of the mild galvanic current, will rapidly produce an amelioration of the symptoms, and, if used immediately subsequent to confinement, will absolutely prevent the conditions, and the long train of evils which will surely follow, and will restore the whom rapidly to its normal state. The galvanic current, judiciously applied, will accomplish this restoration in three weeks."—*Weekly Med. Review*.

**TREATMENT OF HICCOUGH BY COMPRESSION OF THE PHRENIC AND PNEUMOGASTRIC NERVES.**—To properly perform this operation, Dr. Grognot advises us (*Bull. gén. de thérap.*) to use the thumb and index finger, one on either side symmetrically, applying pressure sufficiently strong to cause the spasm to disappear. One or two minutes, as a rule, sometimes less, are sufficient; meanwhile the patient's head must be kept immovable. Four or five centimetres of the inferior clavicular portion of the sterno-cleido-mastoid muscle lie directly over these nerves, and it is here that the pressure is to be made. *Med. and Surg. Rep.*, Oct. 10th.

**ASTRINGENT FOR THE URINARY TRACT.**—Gallic acid is probably the best hæmostatic in bleeding from the kidneys, bladder or urethra. It should be given at frequent intervals, in doses of about ten grains, and is best taken in water. *Med. World*.

WE understand that Dr. Wallace, of Liverpool has successfully performed resection of the female bladder for cancer by abdominal section, being we believe, the first time the operation has been performed in this country. The patient is progressing favorably, seven days having elapsed since the operation. *Lancet*.

# THE CANADA LANCET.

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## THE MILK DIET.

For a long time past the belief has been propagated by the medical profession that milk is a food suitable for all ages and conditions of man. But it is quite possible to overdo even a good thing and that is just what we believe has happened in regard to milk as a diet. To make this statement good requires but little reflection, and less scientific information. If for no other reason, individual idiosyncracies will always stand in the way of any attempt at setting up a uniform diet. That this has been the tendency for a generation all must admit. Milk has been persistently extolled and held up to all, whether in sickness or health, as the food of foods. The young, the middle aged and the old are recommended to use it. When sickness overtakes us the injunction becomes imperative, and now we must partake of it, and live on it, whether we have been able to do so before or not. A milk diet is all the rage—the fashionable diet, and even in the calm domain of medicine fashion is not wanting in power and contagiousness.

In making these remarks it is not intended to disparage milk as an article of diet, but rather to ascertain its proper place as food. A thing good in a general sense, may be bad in a particular sense. To this rule, milk is not an exception to the extent that present opinions and practices would lead us to think.

Nature designs milk as the first aliment for the

young. Its constituent elements are exactly suited to the wants of the organism. For a time these conditions work out this design. Soon a change comes over the infant organism, usually ushered in by the process of dentition. Slowly but surely, the child voluntarily and instinctively relinquishes its favorite food. Gradually too, nature's generous fountain dries up, and the child is left to draw on other forms of food allotted to man's use. This looks very much like a hint from nature not to use milk after the period of complete dentition. From these facts we learn at least two things. First, that the infant organism is *peculiarly* adapted to the assimilation of milk. Secondly, that this peculiar adaptation is in a large measure diminished during and after the period of dentition. It follows, as a natural consequence, that adults have a smaller capacity than children for the assimilation of a milk diet. We know well, that many adults are unable to digest milk in any form. Some young children, even, are unable to do so. Most persons can dispose of a moderate quantity, but this affords no proof of adaptability.

These remarks are also supported by evidence taken directly from nature herself, by the common people. The cheese-maker never searches for the true ferment of milk in the stomach of the bullock. He always goes direct to the stomach of the calf, where he knows he will find it in greatest abundance. Here, we have a scientific explanation of facts, known from observation and experience. It is not assuming too much to say, that this gastric ferment, in the young, is assisted in the work of assimilation by the other secretions of the alimentary tract. Notwithstanding these unquestioned advantages, there are times in the history of the young, in severe cholera infantum, for example, where the continuance of milk is certain death. In drawing our comparisons, we should also bear in mind, the great difference between human and cow's milk. The former containing less casein coagulates much less firmly, and altogether is more easily digested. Nevertheless, experience has proved that children may do very well on cow's milk, with proper care and attention.

If our points are well taken, caution would seem to be suggested in recommending the use of milk to adults, even in a state of health. This is especially true of sweet or uncoagulated milk. The artificial coagulation of cow's milk is much

more perfect than that accomplished in the adult stomach. Hence buttermilk, and peptonized milk are more easily appropriated and much more suitable to the greater number of individuals. (See *Therapeutics of Buttermilk*, LANCET, August, 1883.) It is in this form that the porridge eaters of Scotland and Ireland use milk. When we come to consider milk as diet for weak digestion, and those prostrated by acute disease, we tread on dangerous ground, and if possible, words must be more thoughtfully and carefully spoken. It is hard to believe that disease creates anew a tolerance for milk. It is exceedingly unlikely, that a stomach which habitually rebelled against milk, in a state of health will become tolerant in a state of disease. The chances are all against such a belief. Again, consider how irrational it is to ask a person laboring under such an exhausting disease as typhoid fever, to live, weeks together, on a diet on which he would have starved, when well. As in the case of the child with cholera infantum, we have to consider also the probability of the formation and accumulation of firm and indigestible coagula, causing gastric and intestinal irritation and increase of temperature. This last difficulty may be effectually overcome by using only milk previously peptonized. This has the disadvantage however, of sometimes causing relaxation of the bowels, especially in cases where a tendency that way already exists. There is reason to fear that many valuable lives have been sacrificed at the shrine of the goddess of unreasoning routine. The whole question needs a more careful and patient investigation than it has yet received. Until such time as we have more convincing proof of the universal adaptability of milk, a middle course will be the safest to pursue. A mixed diet of broths, minced or pulped meats and jellies, eggs, farinaceous articles, and milk, in cases believed to be suitable, will be found, on the whole, to answer any indication, and to give the most satisfactory results.

#### LEPROSY IN NEW BRUNSWICK.

We have before us a most interesting report on Leprosy in New Brunswick, by Dr. J. C. Taché of Laval University and Dr. A. C. Smith, of the Medical Council of New Brunswick, and visiting physician to the Lazaretto at Tracadie. The report was prepared in answer to a series of questions

submitted by His Excellency, the Minister of Foreign Affairs of the government of the Sandwich Islands.

The disease is known only in the two Counties of Gloucester and Northumberland, where it has existed for many years. It is the true Elephantiasis græcorum, and appears under two forms, viz : tubercular and anæsthetic leprosy, which so-called forms are, however, in the opinion of Drs. Taché and Smith the result of one common morbid state. In the former the skin and mucous membranes are chiefly involved; in the latter the nervous system. It is a specific disease characterized by the slow development of nodular growths in connection with the skin, mucous membranes and nerves; and, in the latter case, by the super-vention of anæsthesia, and a tendency to ulcerative destruction. The disease rarely attacks the extremes of life, and indeed early infancy seems to possess complete immunity from it, early adult life showing the greatest number of cases. The progress of the disease is very variable, sometimes destroying life in a few years, while in other cases it lasts for a long period. There are now two cases in the Lazaretto which have lasted with constant symptoms for the respective periods of forty-six and thirty years. The early symptoms are a general uneasiness, drowsiness, irrepressible instinctive anxiety, undefined and not very severe pains followed by hyperæmia, hyperæsthesia, insensibility, macula, pemphigus, atrophic manifestations, and alopecia, especially of the eyebrows.

It is more common in the male sex than in the female, but the proportion varies as to time and place. It attacks persons of all races in proportion as they are exposed, lepers of French, English, Scotch and Irish descent having been known in New Brunswick, as also lepers of mixed origin. The persons afflicted with leprosy have with three exceptions belonged to the classes of farmers, fishermen and lumbermen and a mixture of them, being neither in affluence nor in destitution. The habits of the people generally are good, their sanitary surroundings as good as in neighboring parishes—domestic and personal cleanliness vary; food is abundant and of good quality, and they are robust, healthy and long-lived.

The circumstances which favor the development of leprosy in individuals and in groups of individuals are the close intimacy of family



life and the great sociability of the people. It does not appear that any particular circumstances of life favor the progress of the disease when once established in an individual, beyond what applies to all ailments, viz: anything which tends to depress the patient either mentally or physically has the effect of hastening the final scene.

While in the opinion of the writers the disease does not appear to be hereditary, they recognize the fact that offspring of leprous parents have transmitted to them certain organic peculiarities which render them easier preys to the disease when they are exposed to it. In answer to the question whether leprosy is dependent on or connected with syphilis or any other disease the reply is pointed, viz: that leprosy is a disease *sui generis*, and has no connection whatever with any other disease. The cause of the propagation of the disease Dr. Taché holds to be *contagion*, at the same time he recognizes the fact that leprosy is occasionally produced spontaneously. In support of the theory that the disease is contagious he instances a case of leprosy developed in a healthy young man by a discharge from a leprous ulcer coming in contact with his shoulder, the skin of which has been abraded by carrying the coffin containing the body of a deceased leper. Though his genealogy was traced for several generations back there had never been any leprosy in his family. His sister developed the disease a few years after. One husband of a leprous woman and one wife of a leprous husband have had the disease in New Brunswick. The disease is frequently manifested in the sexual organs, and the inference drawn is that if the disease can be transmitted by actual contact, sexual intercourse may be a means of so transmitting it. Lepers are not permitted to mix freely with other members of society, but segregation has not latterly been as fully carried out by violent measures as it was formerly. The clergy unceasingly use their influence with the people in the direction of segregation, and with the happy results that all lepers with two exceptions have for many years resorted to the Lazaretto and remained there till the time of their death. The Lazaretto is maintained at the public expense, the inmates are under the care of Sisters of Charity, are ministered to by a chaplain and visited by a physician. The sanitary conditions are good, and though all is on a modest scale it

has answered the purpose. The attendance and nursing are excellent, and the unfortunate inmates rendered as happy as they can be under such hopeless conditions.

The number of lepers in the institution in May 1885 was twenty-one, and the tabular report for the past ten years shows a decrease in the province from thirty-six in 1875, to twenty-five in 1885. This diminution in the number of lepers is due in the opinion of the authors of the report, to segregation of those affected, and to the improving condition of the population. The history of the disease shows that all medication is useless for its cure, but shows also that good hygienic conditions alleviate to a great extent the suffering of those afflicted, and lengthen the term of life left to them. The disease always kills unless the patient is carried off by some intercurrent disorder—spontaneous cure being unknown. Dr. Taché cites an interesting case which space will not permit us to give, from which he draws the following conclusions: That leprosy may attack a person free from any hereditary taint; that the fecundity of a woman may be preserved even when the malady has lasted a long time; that cohabitation may not communicate the disease; that children are born healthy, notwithstanding the existence of leprosy in the parents, although they may acquire it.

#### UNPROFESSIONAL ADVERTISING.

The question of unprofessional advertising is an old one, one which has been discussed from time immemorial, especially by the older members of the profession, who it may be supposed having made their mark by superior skill and hard work, object strongly to having their locality invaded by some young doctor, who by liberal use of printer's ink, flaming signs etc. makes or attempts to make a vigorous invasion of the older practitioner's territory. Now while the code may press heavily upon a young man who has thoroughly prepared himself for his profession, while he may and in most cases does grow restive under the silence imposed upon him, he sometimes adopts means for advertising himself which are certainly more unprofessional than gaudy fanlights, finger boards and all the other objectionable ways of letting the public know where he is. We refer to the charges made

by some regularly qualified practitioners for professional work. The term professional charge is hardly the proper one to use—price would be a better word to apply to the money paid for such jobs. No doubt many a young physician, struggling with pecuniary difficulties would be glad to gain a hold in his community by charging fifty cents for an office consultation did not the *esprit de corps*, properly belonging to the profession, prevent him from stooping to such means to establish a practice. There might be some excuse for such action in the case of a man struggling for existence, with whom it is fifty cents or nothing. But what shall we say of men well-endowed with this world's goods, who for the sake of increasing their popularity with a certain class, do a regular office practice at fifty cents a consultation, and *throw the medicine in*. Is not this a system of advertising more pernicious than the method of the man who says: "I shall put my name in the dailies, I shall put up all the signs I choose, I shall advertise myself openly, and what are you going to do about it?"

It is pretty generally admitted that no members of the community do more charitable work than medical men, but if they work for charity, then for any sake let it be called charity, and do not let the charge be lessened. If a man choose to pay visits, or give advice gratis surely he has a perfect right to do so, just as much right as has a grocer to give away packages of tea, or a dry goods merchant to present pieces of flannel to the poor of his neighborhood. But when a bill is paid let the patient understand fully that he is paying for say only one half the visits, and that the Dr. presents the rest of the bill. This will protect other members of the profession, who may not have the inclination to do much work for charity, and at the same time tend to keep up a certain amount of respect for professional services in the eyes of the poorer classes. Perhaps some of the fifty cent men consider themselves sufficiently paid at fifty cents a consultation, *medicine thrown in*. No doubt the advice is in such cases nearly as watery as the medicine, and the patient is not much the gainer after all. This "medicine thrown in" sounds very like the "prize in each and every package" cry which we hear from the mouths of touters of candy packages, etc., at the doors of booths in a circus ground.

Naturalists tell us they are undecided whether it is the sense of sight or smell, which guides the turkey buzzard to the spot where the carcass lies. The bird may not have been seen in the vicinity for days, but let an animal die and be drawn out to the fields, and lo! they appear from the north, south, east and west, as if coming from the clouds. These same students of nature would be equally puzzled to explain how certain members of the *genus medicus* find their way to the scene of an accident. Explanation is difficult, but true it is that some men seem to scent an accident in the air, and localize it with unerring precision. They come as if from the clouds, but are sufficiently material to make themselves well-known to the reporter and bystanders. They have even been known to suggest to the medical man of the family when a consultation would suit them etc. Then there is the society advertising dodge, so well known, by which the Dr. makes himself agreeable to so many mammas, the "lodge" advertisement and others too numerous to mention. If we allow ourselves to moralize on the subject, and to ask why such a state of affairs should exist, we are met by numerous difficulties. Is it because the profession is sadly overcrowded? The answer is, not more than that of the law, and yet we do not hear of the same heartburnings among the members of that profession. The medical student is regarded by the ordinary lay mind as a being rather outside the pale of common decency, but as soon as he can sign himself M.D., and has begun practice all this is changed, he then takes his place as a respectable citizen, and by common consent is at least as good as his cousin the lawyer, and it cannot therefore be any inherent badness that makes the M.D. prey upon his brother's flock.

The question will in all probability remain unanswered, but we should be greatly gratified if some of the fifty cent consultation men, and twenty-five cent vaccination men would give us some explanation why they pursue a policy which lowers them in the eyes of their patients, makes bad blood between members of the profession, and eventually keeps money out of their own pockets.

#### A NEW HYPNOTIC.

A new hypnotic has been brought forward by Drs. Dujardin-Beaumetz and Bordet. The name

of the compound is phenyl-methyl-acetone, which being rather cumbersome has been replaced by the name *hypnone*, on account of its therapeutic use. From experiments made by Popof and others it appears the compound undergoes a decomposition, resulting in the formation of carbonic and benzoic acids, and is eventually eliminated by the kidneys in the form of hippurates.

It is a liquid at 20° C., and its boiling point is 198°. It has a specific gravity of 1015 to 1032: is not soluble in water, and has an odor resembling cherry-laurel. Its formula is  $C_5H_5CoCH_3$ . It was discovered by Friedel in 1857. The dose for an adult is from three to five drops, and is best administered in a little glycerine in a capsule. It produces profound slumber, and is said to be superior to chloral or paraldehyde in the insomnia of alcoholism. It was given to nine patients for fifteen days without producing any symptoms of intolerance. Owing to the elimination of acetone by the lungs, the breath became offensive. One advantage of the new drug is the small dose necessary to produce sleep.

**THE COCAINE HABIT.**—From Chicago comes a note of warning as to the abuse of cocaine. Dr. Bradley, a prominent physician had been addicted to the use of the drug in excess, and in a few months became a mental and physical wreck, and at the same time had injured the health of his wife and five children, some of them seriously. It appears to be more fascinating than alcohol, opium, chloral, etc., and the victim seems even more helpless to throw off its yoke. Several physicians have testified to its baneful influence, stating that it works ruin much more rapidly even than that *bête noir*, morphia. Cases of poisoning by the drug are noticed, in which recovery took place under the action of stimulants and digitalis. The habit has been formed in several instances under the direction of physicians, who, being desirous of breaking off some other habit, substituted a much worse one.

**RHEUMATISM IN VINEGAR MANUFACTURE.**—Mr. Robson calls attention (*British Medical Journal*) to the fact that persons exposed to the fumes of vinegar are more subject to rheumatic affections than others. Acute rheumatism, rheumatic gout, lumbago and tonsillitis form the majority of cases

of disease among the workmen employed at the vinegar brewery, of which Mr. Robson has medical charge. It is generally accepted by the workmen themselves that the vapors to which they are exposed cause these affections. Mr. Robson's theory is that the elimination of effete material by the skin is interfered with by the action of the acetic acid, which checks free perspiration. He further suggests that the acetic acid may, when introduced into the system, be changed by a chemical process into lactic acid.

**THE LIGATURE IN OVARIOTOMY.** Dr. Lawson Tait, writing to the *British Med. Journal*, Nov. '85 expresses his preference for ligation of the pedicle in ovariectomy. Dr. Keith, of Edinburgh, prefers the cautery, which he calls "the only perfect method of dealing with the pedicle, for by it all risk of after-bleeding is avoided." Dr. Tait mentions the fact that he has lately performed his one hundred and thirty-second operation for cystoma since January 1st, 1884, without a single death. In ligating, he uses the Staffordshire knot, and states that his only case of after-bleeding was due to his not using that knot.

**PERMANGANATE OF POTASH IN AMENORRHEA.**—This drug in grain doses three times a day will be found useful in cases where the flow is too small in amount, or where it is delayed. Ringer states that it has been known to establish the function even after the lapse of two years. Dr. Döring, of Chicago, in a report as to its efficacy, states that to be of use it must be given in considerably larger doses, two to four grains thrice daily midway between meals, but that in such case it deranges the stomach. He also advocates the use of large draughts of mineral water to be taken after the permanganate. Dr. Döring's larger dose should be taken in capsules. Mr. Ringer prescribes it as follows:

R Permanganate of Potash, 1 gr.  
Kaolin,  
Petroleum Cerate, of equal parts  
q s., ft. pil. 1.

Sig. One three times a day.

**MIDWIFERY PRACTICE AFTER EXPOSURE TO SEPTIC POISON.**—The majority of competent observers no longer claim that it is necessary to quit attendance upon cases of labor after exposure to septic poison.

It is held that thorough disinfection is all that is required for the safety of the patient. Dr. Angus MacDonald, of Edinburgh, emphasizes this—but makes his disinfection process very thorough, viz: complete change of clothing, hot bath, hands, face, beard and hair rubbed with turpentine, then with a solution of bichloride of mercury, after which he states there is absolutely no danger of carrying infection to the patient.

**PERSISTENT CONSTIPATION.**—Dr. Davies writing to the LANCET, gives the following treatment as having restored a case of obstinate constipation in a young man æt. 23. He ordered Ext. cascara sagrad ʒi; Tr. nucis vom. ʒx; Tr. belladonnæ ʒv to be taken in water night and morning; the abdomen to be rubbed firmly from right to left for ten minutes every morning, and the diet to consist largely of porridge, brown bread and stewed fruits, with total abstinence from tea. The result was most happy, as the patient was cured in three weeks.

**TREATMENT OF SCABIES.**—Dr. Comessati, in *Pharmack Zeit*, 1885, gives the following as his treatment for itch. The whole body is washed at night with a solution of hyposulphite of soda, four ounces to one pint of water. The next morning the skin is sponged with dilute hydrochloric acid, one ounce to a pint of water. The chemical reaction gives sulphur, sulphurous acid, and sodium chloride, and one application is usually sufficient to cure the disease.

**HOW TO TAKE A PILL.**—Dr. Ashwallis in *The Med. & Surg. Rep.* recommends practitioners to try Hanna's method when patients affirm that they "cant take a pill." The directions he gives are: place one or two pills *under the tongue*, then take a mouthful of water and swallow just as in the act of drinking. He says that invariably the patient is astonished to find the objectionable pellet gone and sometimes examines his mouth with the finger to assure himself it is not there. The explanation is that in the act of drinking the tongue is carried back upon itself, and the current forces the pill down the oesophagus.

**HYDROPHOBIA INOCULATION.** M. Pasteur has now under his charge 78 patients for treatment of hydrophobia. Four little children are to be sent

to him from Newark, N.J., by S. S. Canada. It is stated that the French Government intends asking the Chamber for funds to enable Pasteur to establish a hospital for the treatment of rabies. No doubt a number of patients will be sent from Milwaukee, where there is just now a large number of cases, one death having occurred from the disease.

**PILOCARPINE IN ALCOHOLIC INSOMNIA.**—Dr. A. B. Isham (*Medical News*) gives his experience as to the effect of this drug in the insomnia produced by the excessive use of alcohol. He gives one-third of a grain of the muriate, and says that the patient wakes from sleep wonderfully changed for the better both mentally and in appearance. He believes that it lowers cerebral blood pressure, aids in the elimination of alcohol and increases the absorption of oxygen. He also recommends it for the depression following a debauch.

**ANOTHER CURE FOR STAMMERING.**—A writer in the *Popular Science News* gives the following as a method for the cure of stammering: "Go into a room where you will be quiet and alone, get some book that will interest but not excite you, and sit down, read two hours aloud to yourself, keeping the teeth closed. Do the same thing every two or three days, or once a week if very tiresome, always taking care to read slowly and distinctly, moving the lips but not the teeth.

**ADMINISTRATION OF PARALDEHYDE.**—The following formula is given by M. Hereboullet, *Gaz. hebdom. de méd et Chir.*, as a good one for the administration of paraldehyde:

Paraldehyde,	-	-	150 grains.
Alcohol (90 per cent.)	-	-	720 "
Syrup,	-	-	900 "
Tincture of Vanilla,	-	-	30 "
Distilled Water,	-	-	450 "

One drachm of this contains fifteen grains of paraldehyde. Dose not to exceed four drachms.

**TREATMENT OF WARTS OF THE PENIS.**—Nussbaum treats the small soft warts which frequently cover the penis, by first washing them twice daily in salt and water, and afterwards sprinkling with calomel. The reaction of the residual sodium chloride and mercurous chloride produces mercuric chloride or corrosive sublimate. This treatment,

he claims, cures the warts rapidly without causing the least pain or detention from business.

**APPOINTMENTS:**—Dr. A. D. Williams, gold medallist of Toronto University, 1870, has been appointed to the chief command of the General Hospital at Georgetown, British Guiana. The salary is from \$5,000 to \$6,000.

**THE LATE W. H. VANDERBILT.**—We regret to announce the death of W. H. Vanderbilt. His name deserves to be held in kind remembrance by the medical profession as the donor of half a million dollars to the College of Physicians and Surgeons of New York.

**ERROR.**—In Dr. Grant's article in last month's issue an error inadvertently crept in. On page 95, 2nd column, 15th line from bottom, malignant asthma should read malignant *anthrax*.

**PERSONAL.**—Dr. J. W. Rosebrugh, of Hamilton, Ont., has been elected a Fellow of the British Gynecological Society, and a corresponding member of the Boston Gynecological Society.

Dr. Frank Hamilton Mewburn, son of Dr. Mewburn of this city, has resigned the home surgery of the Winnipeg City Hospital, which he held for nearly four years, and has been appointed Medical Officer to the Lethbridge Coal Mines. N. W. T.

The death of Dr. Albert H. Smith, of Philadelphia, at the early age of 52 years, is announced in our exchanges.

**CORONER**—D. C. Leitch, M.D., of Dutton, Ont., has been appointed Coroner for the County of Elgin.

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### WILLIAM MARSDEN, M.D.

It is with profound regret that we notice the death of Dr. Marsden, one of the oldest and most prominent physicians in Quebec. Dr. Marsden was born in Lancashire, Eng., in 1807, and was consequently in his 79th year. He came to Quebec in 1812, was educated in the Royal Grammar School there and completed his medical education in London and Paris, and received the license to practice in 1830. He has therefore been in active practice for upwards of half a

century, and filled many important positions in connection with his profession. He was an M.D. of Harvard University, and Bishop's College, Lennoxville, conferred upon him the honorary degree of M.A. For many years he was president of the College of Physicians and Surgeons of Quebec, of which he was senior Governor. He was also an honorary member of various literary societies, and at one time contributed largely both to the medical and secular press. He published a complete history of Asiatic Cholera, its etiology and pathology, commencing with its outbreak in India in 1817. Before the incorporation of the Quebec Medical School and Laval University, he for many years delivered, with great success, courses of lectures on anatomy and physiology, surgery, materia medica and botany. He took an active part in the establishment of the Canada Medical Association and was one of the presidents. He took a deep interest in sanitary reform, and was as energetic in his efforts to prevent the introduction of small-pox into his native city as he was nearly half a century ago to perfect his system of quarantine against an invasion of cholera. The deceased has led a long, useful and busy life, and has literally died in harness. His death is a public loss, and his bereaved family have our respectful sympathy in their affliction.

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### Notes, Queries and Replies.

A correspondent desires answers to the following queries:

1. The best treatment for seasickness.
2. How to prevent laceration of the perineum, and the best method of treatment when it occurs.

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### Books and Pamphlets.

**EPILEPSY AND OTHER CHRONIC CONVULSIVE DISEASES**—By W. R. Gowers, M.D., F.R.C.P., etc. New York: W. Wood & Co. Toronto, Williamson & Co.

Good ale needs no broom: therefore it is quite unnecessary, in introducing this work to the profession, to annex to the author's name, the whole of his caudal appendage. The book is good all through. It will be best appreciated by those who are already best acquainted with the diseases treated of. It is, however, not improbable that

junior readers may regard the past, devoted chiefly to the semeiology and statistics of epilepsy, and taking up more than half of the volume, as unnecessarily long and too liberally diffuse; but whoever, young or old, sets determinedly to work, will find the work growing in favour the farther he advances in its careful perusal: certainly when he reaches the last four chapters, devoted to the Pathology, Diagnosis, Prognosis and Treatment, he will say that his patient devotion is amply rewarded. Indeed it might not be wrong to suggest to those who have little surplus time at command, to take up these chapters first, not however with the purpose or desire of ignoring those preceding: for they are of absolute requirement in the satisfactory study of the others following; but because his appreciation of the latter will be so high that he cannot refrain from reading all that precedes, and he will certainly read again with avidity and with augmented profit, the terminal four above indicated.

**A TREATISE ON NERVOUS DISEASES.** their Symptoms and Treatment, by Samuel G. Webber, M.D., Clinical instructor in Nervous Diseases, Harvard Medical School. Boston. New York: D. Appleton & Co. Toronto: Williamson & Co.

This work presents in a small compass the essential points as to etiology, symptoms, diagnosis and treatment of nervous diseases. The author's style is plain and pointed. He appears to say just what is necessary and no more: few books being found with less padding than this one. The work is intended for the use of the general practitioner, and we believe the writer has made a valuable addition to the literature of the subject, being sufficiently limited to render it handy for easy reference. It is not intended for specialists, many parts being greatly condensed. One of its best features is the condensation of the anatomy and physiology of the nervous organs found in the second chapter, and which must prove very useful to the general practitioner who has not time to keep himself fresh on these difficult and intricate subjects. The introductory remarks, as to the methods of testing sensation and motion will be of very great service to those who have not had the opportunity of devoting much time to the study of nervous diseases. The book is carefully and thoughtfully written and will repay a careful

perusal by students and men who are doing a general practice.

**THE MANAGEMENT OF LABOR AND OF THE LYING-IN PERIOD**, by Henry G. Landis, A.M., M.D., Professor of Obstetrics in Starling Medical College, etc., 8vo. pp. 334. Philadelphia: Lea Bros. & Co., 1885. Toronto: Williamson & Co.

This addition to obstetrics appears in a very attractive form, the typographical appearance being excellent. The author is clear and concise, and we have no doubt the work will be of value to the young practitioner. It supposes an acquaintance with "the anatomy and physiology of the parts involved, and of the mechanism of labor," and is intended simply as a "guide to practice." The result is that it is nearly useless to the student, while it cannot rank as a treatise which an experienced practitioner would care to consult. The *raison d'être* of the book is not therefore very apparent. The subject matter is all good, and the opinions expressed entirely orthodox; but nothing new has been brought forward. It may save time in referring to larger treatises for simple facts without details.

**GRIP FOR 1886.**—*Grip* Publishing Co., Toronto: This is the 13th year of publication of Canada's Comic Journal. Improvements are promised for the current year in the way of increase in size, alteration in style and improved facilities for the production of cartoons. The price will remain the same. The CANADA LANCET and *Grip* for 1886 will be supplied for \$4.50.

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### Births, Marriages and Deaths.

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On the 27th of Nov., Jacob Smith, M.D., of Ridgetown, Ont., in his fifty-fifth year.

On the 1st Dec., C. J. Philbrick, F.R.C.S., E.C.S., of this city in his 70th year.

On the 7th Dec., W. C. Edmondson, M.B., of Oshawa, aged 29 years.

On the 10th Dec., Chas. E. Cotton, M.D., of Cowansville, Que., aged 69 years.

On the 15th Dec., S. Cory, M.D., of Stamford, in his 81st year.

# THE CANADA LANCET.

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## Original Communications.

### THE EXPERIMENTAL TRUTH IN RELATION TO DISINFECTANTS.

TRANSLATED BY DR. J. WORKMAN, TORONTO.

The following article (translated from the Spanish) is presented in the September number of the "*Revista Argentina de Ciencias Medicas*," of Buenos Ayres. Probably some, if not many of the statements of the author will appear rather marvellous to Canadian medical reader at the present time, considering the great practical value which has been attached to disinfectant processes during the course of the small-pox epidemic, which has proved so destructive in the City of Montreal and the adjacent villages. If, as seems to be generally believed, these processes are efficient in the prevention of infection, and the statements of the Spanish experimenter, *Dr. Jose de Letamendi*, are perfectly reliable, the conclusion seems inevitable, that microbes have no part in the causation of infectious diseases, or that if they really are the conveying agents, the accredited destroying means of disinfection must accomplish the desired purpose by virtue of some other sanitive process, distinct from that of killing the microbes, for this result would seem to be unattainable even by the most powerful chemical agents hitherto employed. *Letamendi*, as the reader will find towards the end of his article, reduces his disinfecting means to the two primitive agents, *water* and *fire*. In this simplification of disinfection, he has, perhaps, come as near to the truth as persistent experimentation and common sense enabled him to attain. We now submit the article as it was presented in the *Archivos de Therapeutica*, in Spain:

"The conflict with a determinate species of the microbes may be as relates to the family, individual or collective. In taking the field in single

combat we must have recourse to the therapeutic agents which kill the aggressive horde in the collective combat (epidemia from contagion); as soon as the microbes have assailed a population, recourse must be had to a prophylactic means, which, by killing the germs emanating from every diseased person, in his *excreta*, and adhering to retentive objects (*contagium vivum*), cuts short the epidemic process. By virtue of these indications, and by calling disinfectants the means which, in individuals and things, kill the infecting microbe, the following two problems are naturally presented:—

1st. Is curative disinfection, or that of individuals, possible? 2nd. Is preventive disinfection, or that of things, possible?

Let us see. At our very outset sound sense imposes on each of these problems a certain limitation. Here is the limitation of the 1st problem:—It is indispensable that the agent destroying the microbe shall not overpass, in the diseased person, the limits assigned to therapeutic disturbances. Without this limitation it would be possible, in killing the cause of the disease, to kill our patient also. The limitation of the 2nd problem is this:—It is requisite that the agent killing the microbe shall not attack retentive objects unless within certain prudential economic limits. Goods, articles of utility, capital, wealth, are products of industry which are esteemed by the people as the equivalent of their means of life.

Having now stated the theo-ro-practical problem, let us seek its solution, not in mere arguments, but in real facts, positive and correct. In this field nothing exposes more to error—unpardonable error—than submitting our own conduct to outer-authority; be it that of a man elevated to the undisputed position of a demigod, or that of a precedent established beyond appeal by a judge. Facts have truly a decisive force; but they must be facts seen, not heard from others, and not assented to from mere laziness to test them. I proceed, therefore, to present the results of my own experiments, some of which were made in 1865, when the *religion of carbolic acid* was introduced into Spain, and others during the present year, recommending to the reader, beforehand, the utility of testing them by himself, or in association with some person expert in the matter. The microbes subjected by me to experimentation, have been the *bact-rium*,



the *diplococcus cadavericus*, the *bacteridium carbunculosum* (in attenuated culture), the *diplococcus* of roseola and of hogs, the *bacillus phymatogenus* or that of *phthisis*, the *bacterium of urea*, and others of less importance.

The agents and the results of reactions were as follows:—

1st. Phenyl, or carbolic acid pure, crystallized; watery solution of 2 per cent. Result.—All the microphytes continuously in life.

2nd. Idem, incomplete cold solutions or emulsions, from 5 to 10 per cent. Result.—Between the layers of microphytes imprisoned in the coagulum of the albuminous substances of the putrilage and the liquid of the culture, numerous free *cocci*, living, and swimming about in a sea of microscopic drops of emulsified phenyl, moving with the impulses and in the style of microbes, up to the seventh day.

3rd. Considering the trivial solubility of pure phenyl, the same solutions as the previous were aided and completed by means of some drops of alcohol. Consequent disappearance in them of free phenyl was noted. Result.—An immediate augmentation of the activity of the microbes. The alcohol, by debilitating extraordinarily the action of the phenyl or pure carbolic acid, caused practically the obtainment of a carbolised water of over 3 per cent. This fact, which I had observed in 1865, has been verified by Koch in relation to divers species of *bacilli*.

4th. Liquid carbolic acid (by natural deliquescence, with alteration of its chemical constitution). Enormous doses; 10 grains of pure reactive to 2 grains of putrid urine or the putrilage of flesh, that is to say, 100 to 20. Result.—Large islands or clusters of bacteria imprisoned in the coagulated albuminoid substance; intermediate lakes peopled with free bacteria in their greatest activity. Observed two days. On the 8th day the liquid appeared turbid, and when again subjected to microscopic examination, it gave a notable increase of free bacteria.

5th. Thymol, or thymic acid, pure, amorphous. Experiments and results similar to those by phenyl.

6th. Salicylic acid; solution of 1 per 2,000; microphytes living *ad maximum*.—Solution of 1 per 1,000, microphytes living, but rather remiss in

their movements. Observed to the fifth day; they continue living and agile.

8th. Lime. Action nil; all living.

9th. Mixture of caustic soda, and barilla, without definite dosage, but not under 10 per cent., and the same as is used by me in my own laboratory for perfectly cleaning in twenty-four hours, the glasses of varnished plates. In one drop of this mixture I found a good number of *bacilli* and *cocci* of various species in full activity, which had proceeded from micrographic preparations of the same sorts, previously worn out and put into the same mixture in order to clear them of mastich.

10th. Pyrogallie acid; solution at 10 per cent. Result.—Nil; all the bacteria alive and in motion, free from the meshes of the coagulum. The observation was followed up to the twentieth day, when all were living *ad maximum*. This explains why hides, either whole or cut, may infect with carbuncle.

11th. Ammonia, pure. Result.—All alive continuously.

12th. Sulphohydrate of ammonia, pure. Result.—All alive in 24 hours, though torpid in movements, and the field turbid, without doubt, from the reduction of the sulphur.

13th. Sulphate of iron at 30 per cent.; solution slightly acid. Result.—All the microbes living.

14th. Sulphate of copper; saturated cold solution. Result after 24 hours:—All living, but with one singular circumstance; many of the bacteria show a sharp twisting, over half their length; but on returning to observe them on the fifteenth day, they all continued in life and in notable motion.

15th. Essence of turpentine, pure. On the fourth day all continued in life; and on the eighth day the same.

16th. Chloride of mercury (corrosive sublimate). Result.—All living. Observation followed till the third day; all the microbes living free from the coagulum and very active.

17th. Boracic acid. Saturated aqueous solution, cold (4 per cent). Result.—All alive. Observation continued until the fifteenth day.

18th. Picric acid. Saturated aqueous solution, cold (1 per cent.) Result.—All living, swimming about, free from the meshes of coagulum. Observed again on the fifteenth day, still living.

19th. Picric acid, obtained by transformation of

carbolic acid by a sufficient quantity of nitric acid Result, as the last.

20th. Cyanuret of potass ; aqueous solution at 4 per cent. Result.—All living and more excited than ordinary. On the eighth day they continued in the same state.

21st. Potassic picro-cyanuret ; aqueous solution at 4 per cent. Result, as the preceding ; all the microbes swimming lively between beautiful crystallizations in the form of a double brush, characteristic of the reaction of picric acid on the cyanuret of potass.

22nd. Picrate of ammonia, pure. Result.—Large clusters or layers ; but all the microbes alive and free.

23rd. Permanganate of potass ; aqueous solution at 5 per cent. Result.—All alive, and in addition, the permanganate decomposed from being robbed by the microbes of one equivalent of oxygen.

24th. Arsenious acid ; aqueous solution, cold, at 1 per 1000, that is to say, almost saturated. Result.—At 24 hours (when writing these lines), all alive, as if nothing had happened.

25th. Iodide of bromine. Application useless in practice, because the alkaline salts of common or natural waters form with the iodides or bromides combinations inoffensive to the microbes.

26th. Sulphuric, nitric, and hydrochloric acids ; aqueous, 1 per cent. solutions. Result.—All indefinitely alive.

27th. Aqua regia, pure (nitro-muriatic acid), equal parts. Result.—All alive on the fifteenth day (!!!). Such is the effect of aqua regia, a liquid that dissolves everything, from gold and platinum down to liver and brain.

28th. Nitrate of silver ; saturated solution, cold, with excess of crystals and exposure to light for a whole day. Result.—The silver, reduced by the light, has combined with the substance of the cuticle of the microphytes, but it has not penetrated them ; since, though as black as charcoal, they continue alive, swimming with marvellous agility, in spite of so much metallic silver which each of them carries. Only those entangled in the meshes of the coagulum are motionless, in the state of real microderms, or bacterial pellicles, as well in layers as in islands. Though this is the most powerful reagent, that is, from rendering a greater number of the microbes motionless, besides altering their

integument, yet, in preparations of some days' standing, living *cocci* and *bacilli* were seen swimming. In a specimen of the *bacteridia carbunculosa*, treated by this process for the purpose of better photographing it, I saw, on the twentieth day after sealing the preparation, a multitude of bacteria still in motion, with remarkable activity, in spite of their coat of metallic silver (!!!).

And now I ask, in view of these facts, in face of the quality of the substances employed, and the enormity of the doses, what have the storm waters left behind them ? Will any physician be so simple as to believe, that among the substances prized as disinfectants, there is one capable of killing the *contagium vivum*, either *inside* or *outside*, either in individuals, by cutting short the process of an infectious disease, or in retentive articles, by hindering the development of an epidemic ? Will there be any association, council, minister or governor, who will rest tranquil after having assented to proceedings of disinfection, which experimental facts, carried to the extremes shown in those herein related, declare to be absolutely useless, besides being offensive, expensive, and injurious ? If the strong doses (some horribly mortal to individuals) which I have signalized, have proved useless, in what doses shall we employ them with success ? And even supposing—and it is no little to suppose—that such doses were really disinfectant, what utility could they offer in practice, either *internally* or *externally* ? If, for example, we should administer carbolic acid in the impossible solution of 10 per cent., on reaching the current of the blood in the quantity of a few drops, or when scattered by an atomiser on the bottom of an ulcer, or on retentive wares, from which it rapidly evaporates, it will not represent then even  $\frac{1}{2}$  per 1,000. Let it be tried, and it will be seen that this deduction is inevitable.

Finally, we have to renounce curative or individual disinfection by means of the death of the *contagium vivum*, and as respects preventive or public disinfection by the death of the *contagium vivum* in retentive objects, we have to abandon, as absolutely impotent, chemical means : the entire abortive police of an infectious epidemic is reduced to these two elements, WATER and FIRE : supreme cleanness, and intelligent and methodical cremation up to complete calcination of articles impregnated with the excreta of the sick. I say “intel-

ligent and methodical," because after a provisional drying by means of sawdust, the carbon, vegetable or mineral, in powder, and the boracic acid, as well as the hermetical enclosing of the articles; all this, with the charge of particulars, ought to be proceeded with by the public administration—the only authority which can realize it—by the formal cremation of these articles at two distinct times; one of drying by a slow fire, and the other of definitive calcination; all to be so executed that the fumes peculiar to ordinary combustion may not carry off, and scatter in the atmosphere, enormous quantities of unburned or incompletely burned microbes. I have been convinced by my experiments that, as a general rule, nothing short of complete "calcination" is a sufficient guarantee for the death of the microbes.

I cannot close this article without mentioning one very important experimental fact, the omission of which might suggest doubts, or even reflections, with some foundation. A good number of the substances used by me, when they are employed in the enormous doses mentioned, although they do not kill the microphytes, yet diminish, or altogether suspend their reproductive energy. For this purpose the only substance which, among those experimented with by me, offers practical conditions, is boracic acid. Borax, which is colorless, inodorous, and slightly acid, inoffensive to persons and things, giving an aqueous saturation at 4 per cent. in ordinary temperature, may be administered internally as "boracic lemonade" without any risk; it is inassimilable or anhistogenous, and though like the other reagents, it does not kill the microbes, on the other hand, in supersaturated solution it restrains their reproduction better than the others. In order to demonstrate this, it suffices to hold under observance two equal quantities of the same culture; one of them immediately supersaturated with boracic acid, and the other left without it; let each of the vessels be closed with glass stoppers which will not altogether impede evaporation. On the fifth day afterwards the difference is amazing; in the liquid supersaturated with boracic acid and having the surface covered with crystals of the same, the *bacilli* have changed for free *cocci*, or bundles of *cocci*, very lively and agile, but in quantity equal to the primitive or a little greater, whilst in the other vessel, for every free *coccus*, or bundle of *cocci* of the former, hundreds of *bacilli*

are moving about, with 4, 8, 16, and more nuclei.

This remarkable influence, however, whilst being of inestimable value for other conceptions, has no useful application in the problem of disinfections, either curative or preventive. In the first place, boracic acid produces such effects only in practical doses and conditions\* (economic, clinical and hygienic), by reason of its natural advantages above indicated. In the second place, every microphyte in passing from a favorable to an unfavorable medium, degenerates, and its fecundity is suspended or diminished, but in its turn it recovers its natural fecundity as soon as it passes from an adverse to a propitious medium.

Let us present a particular example of this sort of cycle of the *contagium vivum*. A person attends a cholera or a smallpox patient, out of his own house, etc.; impregnates his hands with the *excreta* of the patient (the vomit, sweat, pus, crusts, etc). He afterwards washes his hands with boracic saturated water, and in so doing he inadvertently splashes the sleeve of his coat. On this sleeve there are microphytes, not only motionless from dryness, but also from the influence of the boracic acid (if any of it has reached them). This person returns to his own house; his servant next day brushes the coat; the microbes are mixed with the air of the house, and some of them get on the soap, or into the water which his daughter makes use of; they are emancipated from the boracic acid, recover their forces on obtaining propitious liquids, in such favorable *climates* . . . and in a little time the daughter of this man falls sick, with cholera or smallpox.

It is a fact that things profit much by their names. Let Killing mean putting out of life; the problem of disinfections is the problem of the death of the *contagium vivum*, and not of its mere attenuation, and for this reason the attenuating virtue of this or that substance will never solve the problem of either curative or preventive disinfection."

JOSE DE LETAMENDI.

It is stated (*Nouveaux Reivèdes*) that essence of peppermint painted on a burn will stop the pain at once.

\*This translation is literally exact, but there must be defect in the text.

## SUBPERIOSTEAL AMPUTATION.

BY J. FULTON, M.D., M.R.C.S., ENG.; L.R.C.P., LONDON.

Prof. of Surgery and Clinical Surgery, Trinity Medical College, Toronto.

The practical utility of the so-called Subperiosteal method of amputation has not been appreciated at its proper value, nor has it received that attention from the profession that its merits deserve. It cannot be called a new operation, although the technique may be new to many surgeons. Attention was first called to this method of amputation seventy years ago, by Walther of Landshut who published a short article on the subject.

In 1859, M. Ollier first demonstrated the utility in amputating, of preserving the periosteum in order to close the medullary canal, and to favor union by primary intention, but owing to the supuration that almost constantly attended the healing of stumps in those days, all attempts at preserving this membrane were abandoned. Since the introduction of the use of antiseptics in surgery, the operation has been revived, and the practice advocated by Esmarch, Tretat, Naas, Volkmann and others who have recommended it as a highly valuable procedure. Dr. Nicaise read an interesting and valuable paper on this subject before the International Medical Congress at Copenhagen last year, in which he stated that he always preserved a portion of periosteum to cover the end of the bone in his amputations. The operation is not described in our text books on surgery, notwithstanding the favor with which it has been received by these distinguished surgeons. So that when it was brought again to the notice of the profession, a few years ago, many regarded it as an entirely new departure in surgery. It is about six years since my attention was first directed to this method of amputation. It at once commended itself to my mind as a most natural and rational procedure in all amputations through bone tissue, and I resolved to put it in practice on the first favorable opportunity. I have since then performed the operation a number of times and always with the most satisfactory results. The operation is especially indicated in all amputations which are necessitated in consequence of disease of the bones or joints. It may be well, however

be overpriced further, to explain what the operation is and how it is performed.

The operation essentially consists in detaching and raising the periosteum from the portion of bone to be removed, to a sufficient extent to cover the sawn end of the bone. The length of the raised periosteum should be equal to the diameter of the bone at the point of removal. The method which I adopt and which I have found to be very simple and easy of execution is as follows: After having made the flaps as in any ordinary operation and sawn the bone through, the periosteum is peeled upwards from the sawn end of the bone, by means of the thumb-nail or raspator, to the required extent—1 inch or one inch and a half. In doing so, care should be taken not to detach it from the muscles, on its outer side, for fear of interfering with its nutrition. Having raised the periosteum to a sufficient extent, an assistant now grasps the end of the bone with stout forceps, the saw is again applied and the portion of bone denuded of periosteum removed. The raised periosteum now falls over the sawn end of the bone like a hood, and its margins may be united with fine catgut sutures, the arteries of the stump are then secured and the flaps brought together in the usual way. The use of sutures in the periosteum is not imperatively necessary. Esmarch and Naas recommend their use, but Nicaise does not regard them as necessary. The periosteal flap hangs over the end of the bone like a hood and very soon contracts adhesions. It will be seen therefore that the end of the stump is left in the same condition physiologically as obtains in other similar parts, the structures from without inwards being, integument, muscle, periosteum and bone. Indeed this is one of the advantages claimed for the operation, "that the sawn surface of the bone is brought into contact with the tissue, which is physiologically fitted for its protection, and to which it becomes organically united most quickly and certainly." Another advantage claimed for this method of amputation, is that the stump is much preferable to any other, inasmuch as the bone has no tendency to adhere to the cicatrix. The bone is also less liable to become atrophied, the stump is firm, and the tissues covering it move freely to and fro. But the most important office subserved by the periosteal flap, is its capability of quickly forming a layer of new bone, and effectually clos-

ing in the medullary canal and guarding against the spread of inflammation or suppuration which may be present in the soft parts. It has been proved by experiments on animals, that a flap of periosteum rapidly closes the open end of the medullary cavity, and prevents the occurrence of osteo-myelitis and also that on the inner surface of this membrane a thin layer of osseous tissue is rapidly formed. M. Nicaise in the paper to which I have already alluded, mentions a case of amputation of the thigh, for chronic disease of the knee in a tuberculous patient aged 42 years. After death, which occurred 29 days after the operation, when the stump had almost entirely healed, the lower end of the divided femur was found completely closed by a septum of thickened and granular periosteum, above which was a layer of newly formed bone tissue about  $\frac{1}{2}$  of an inch in thickness.

The first case in which I performed the operation was a hospital patient, H. W., who was strongly predisposed to bone disease. He was about 26 years of age, had a good family history and was very healthy up to within 6 months from the date of his admission to the Toronto General Hospital in 1879. He was admitted with caries of the bones of the foot, and it was decided to perform Syme's amputation at the ankle joint. On removing the tips of the malleoli it was noticed that the bones were very soft. The stump did badly, the bones showed no disposition to heal and it was finally decided to amputate at the junction of the middle and lower third of the leg. This seemed to me a good case in which to test the utility and value of the periosteal flap, and accordingly I determined to give the patient the benefit of the operation. When the tibia was sawn through in the operation at the point selected, the marrow was found exceedingly soft and unhealthy-looking, so much so that Dr. Aikins who was present remarked that I would have to go higher up. I did not do so however, but simply contented myself by raising the periosteum to the extent of an inch and a quarter, removing the denuded bone, and bringing the periosteal covering over the end of the divided bone. There seemed to be very little difference in the appearance of the two sections of the bone. The stump healed kindly and rapidly, and the patient left the hospital cured within four weeks from the date of

the last operation. Another case which I regarded as a test case, was that of a young man, aged 22, upon whom I performed amputation of the thigh for chronic disease of the knee joint. The family history was not very satisfactory, and the patient presented evidence of constitutional syphilis. The disease of the knee had existed for seven or eight months before his admission to the hospital. With the concurrence of the staff, amputation of the thigh was decided upon. On sawing through the femur the bone was found very soft, and the medullary canal much enlarged, soft, and unhealthy looking. In this case I made a moderately long periosteal flap, so as to cover completely the end of the bone. The case did remarkably well; the stump healed without suppuration, and the patient was going about on crutches in three weeks' time. I might mention a number of cases, somewhat similar in character to the foregoing with equally good results. There is one case, however, of simultaneous amputation of both legs which is worthy of being placed on record. The patient, H. F., aged 60 years, healthy and of good family history, had the misfortune to lose both his feet through frost-bite. A modified form of Syme's amputation was performed by the surgeon, but the stumps refused to heal. The patient had been in this condition for about a year when he came under my care. After due consideration I decided to perform double synchronous amputation of the legs below the knee. This was concurred in by the consulting surgeon. As all surgeons speak of successful operations of this nature as extremely rare, and inasmuch as the patient was advanced in years, I felt considerable anxiety as to the result. On sawing through the tibiae I found the same condition of the medullary canal mentioned in the previous cases, but more marked in the right than in the left tibia. Periosteal flaps were formed in both stumps, and the result was most satisfactory. The left stump was healed completely in three weeks' time, and the right in about four. Considering the age of the patient, and the nature of the case, the success was most gratifying. Taking this case by itself, or all three cases mentioned in this paper together, they do not prove that the success was due to the periosteal flap. But having regard to the success in these cases, and in many others, in which I have adopted this method of amputation, and compar-

ing the results with those in which no periosteal flap has been made, I am forced to the conclusion that it is a most valuable procedure, and one which ought to claim the most careful and considerate attention of all surgeons.

The objections that are urged against this method may be thus summed up. First, that when the flaps are well formed, and the wound properly treated, a good stump without adhesion of the bone to the cicatrix is obtained, and that the muscle will adhere to the end of the bone, and the medullary canal become closed in by a plate of osseous tissue. This is quite true in most cases, but these changes do not take place so rapidly, and the lamella of bone is thinner than when a periosteal flap is made. Secondly, that the formation of the periosteal flap delays the operation. This objection really has no weight, as any dexterous surgeon can make the periosteal flap in from three to five minutes. Thirdly, that the retention of the periosteal flap may lead to the formation of osseous growths around the end of the bone. This may occur, it is said, in young persons, especially when there is kept up any irritation about the end of the bone, but such a formation is exceedingly rare among adults. I have not yet met a single case in which osteophytes have formed in connection with periosteal flaps. This last is the only real objection which can be urged against the operation, and even if supported by experience, is far from outweighing the benefits to be derived from this procedure. As Nicaise has pointed out in the article referred to: "we have arrived at a period in the progress of surgery, in which it is incumbent upon us to study how by attention to small details, we may give our patients the most useful stumps, for the more important measures by which the operation of amputation has been deprived of its chief dangers, are known and practised, with more or less success, by all surgeons." After carefully weighing the arguments for and against the operation, I am fully convinced they show an overwhelming balance in its favor. So strongly convinced am I of the utility and value of the operation, that I now have recourse to it in nearly all amputations, but especially in those cases in which, on section of the bone, the medullary canal is found softened, and in an unhealthy condition. I have been induced to bring this subject before the notice of this association, in the

hope that it may receive more attention in the future than it has in the past.

## Correspondence.

### MORPHINE IN PUERPERAL ECLAMPSIA.

To the Editor of THE CANADA LANCET.

SIR,—As I have seen lately in our medical journals a great deal written on the treatment of this disease, I beg permission to give you my method of treatment, which I have never seen mentioned by any writer, except Dr. Clark, of Oswego, N.Y., and that six years after I had first used it. I will simply give you an outline of my first case so treated, and it will cover the whole.

In August, 1874, I was called to attend a patient seven miles from here, who was being confined with her first child. The labor was tedious and as the head was pressing on perineum she took her first convulsion. I at once applied the forceps and delivered the child. The placenta came away and everything went well for about half an hour after. I say well; I should say "apparently," for she had the peculiar headache in the top of her head, pupils dilated, and nervous twitching of the fingers and mouth. Now, I simply left her alone, for the reason that I had no chloroform, chloral or bromides with me. So I waited to see what next would turn up. I had sent the husband to borrow a horse to go to my surgery (seven miles), to get what I expected I would require, but before he succeeded in getting one his wife had another severe convulsion, and then another. I despatched one messenger to the nearest drug store (five miles), and the husband to my surgery, for chloroform, etc., and I bled the patient freely; then I was done until my messengers should return—and here I was alone with a village full of old women, who had rushed in crying and calling out for me to "*do something*," as the convulsions were coming faster and faster. I tried to explain my situation, but the murmur of discontent went through the house and out of it, up and down the street. Time went on—no messenger arrived. I thought the patient would die myself, so made up my mind to let her do so easily. I gave her a grain of morphia hypodermically, but with the happy result of stopping the convulsions at once, and long before I got my chlo-

reform, etc., she had not one more. It did not produce sleep or any bad symptoms, and after remaining four or five hours I left, first giving her another injection in the same way of a  $\frac{1}{4}$  gr. The patient next day was as well as could be expected, except a swollen tongue where she had bitten it.

Since that day morphia, by hypodermic injections, has been my treatment, and I find the patient rarely has a second convulsion. I never heard of this treatment before, and therefore believed I was alone in its use till July, 1880, when I saw an article written by Dr. C. C. P. Clark, of Oswego, N.Y., in *The American Journal of Obstetrics*. In his article, after bleeding, he recommends hypodermic injections of *two grains* of morphia. He read his paper before the medical Society of Syracuse, and he says, "The magnitude of the dose of morphine that I recommended raised nigh a universal outcry of condemnation among the gentlemen present. Not till I heard this had it entered my thoughts that what I had proposed was so very extreme—so easy had I felt on the pedestal of my actual experience."

Now, though I never use the extreme dose of Dr. Clark (2 grs.), I can endorse his treatment of large doses of morphia, and as I have used nearly every treatment I have seen recommended, except pilocarpine, I can safely say I have seen none equal and so sure as the treatment I have mentioned.

Yours truly,

F. WARREN.

Brooklin, Ont., Jan. 13, 1886.

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To the Editor of the CANADA LANCET.

SIR,—On page 111 you copy a direction for making Koumiss. While milk so treated may answer some purposes as a substitute for "Koumiss," it is in no sense of the word Koumiss as used so extensively in Russia, England or the United States.

Koumiss is not only a fermented but a digested milk, and in properly prepared Koumiss the casein is so finely subdivided that it is impossible of coagulation. Before I knew of the proper formula for making "Koumiss" as it is now made at the "Oaklands Jersey Dairy," I followed similar directions to those given on page 111 of the LANCET, but it only resulted in a partially *fermented* milk, not a *fermented* and *digested* milk. Under the

direction as copied by you it is unfit for use in a few days, the casein gathers in masses, and in a short time will become putrified; whereas in properly prepared Koumiss, if it be kept in a cool place, it is fit for use two months after making. All the sugar is converted into alcohol and lactic acid, and the casein will not become lumpy. Again water should never be added to the milk; if it is desired to have the Koumiss thinner, part of the casein should be abstracted. No foreign substance, such as glycerine, should be used, except in special cases.

In Russia, where Koumiss originated, no yeast is ever used in its preparation. If the casein gathers in lumps and refuses to disseminate when the bottle is shaken, the Koumiss has not been properly prepared, it is merely a partially fermented milk, the casein of which has not been predigested.

The great secret of the success of properly prepared Koumiss is that the casein, the most difficult part of the milk to digest, is already digested, and is ready for absorption by the blood. As Koumiss is but little known in this country, I write this in order that if any of your readers by attempting to make Koumiss under the direction copied by you, and the results are not satisfactory, "Koumiss" be not condemned; because such directions do not as a matter of fact produce a fermented and digested milk, or true "Koumiss." I know of at least 40 different formulas for making so-called Koumiss, each one based on yeast as a ferment—and not one of these 40 will produce predigested casein. Where Koumiss has been longest used all attempts to make a satisfactory Koumiss in competition with that prepared under the formula used in making Oaklands Koumiss, has long since been abandoned as unsatisfactory.

VALANCEY E. FULLER.

Hamilton, Ont.

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### CASE OF EXOMPHALUS.

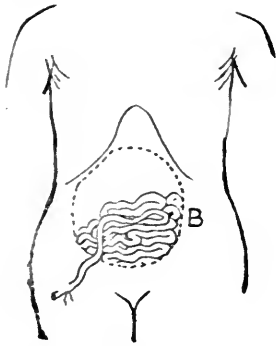
To the Editor of THE CANADA LANCET.

SIR,—I send you a sketch of child which presented at its birth the appearance described: Child was well formed in every other respect; the protusion or tumor was transparent in its lower part; the intestines could be easily seen; in size it was about equal to a child's head.

The circumference of the protusion at its junc-



ture with the skin was so great that it was useless to attempt the bringing of the parts together. The child grew nicely for first week, but dwindled gradually away during the following ten days and



Dotted lines indicate position of tumor, through which are seen the intestines B.

died. An absence of the skin to cover that portion which the protrusion occupied is the only peculiarity of the case, but as I never saw, or read, or heard of anything like it, I send you this sketch.

Yours, etc.,

J. S. SPRAGUE.

Stirling, Dec. 12th, 1885.

### Reports of Societies.

#### MEDICO-CHIRURGICAL SOCIETY.

Montreal, 18th Dec. 1885.

Dr. Roddick in the chair.

After routine, Dr. Trenholme related two remarkable cases of ovariectomy in his practice. One case was operated upon 6 weeks ago, the tumor weighing 34 lbs. The temperature of the patient ran up to  $101\frac{3}{4}$ , 10 hours after the operation, but was normal the next evening, and remained so afterward, there was scarcely any subsequent suffering, hardly any tympanitis, and the patient fairly put on flesh before the end of the first week, she was convalescent on 18th day, and about the house constantly after this time. The second case 4 weeks ago, was even more remarkable, the tumor weighed 55 lbs. (parovarian), temperature 10 hours after the operation  $100^{\circ}$ , next morning it was normal, and together with the pulse remained normal afterward, there was not even the slightest tympanitis, and no subsequent suffering, save a slight back-ache, and the usual soreness

occasioned by the wound. In neither case was there the slightest sign of shock. The remarkable results obtained in these cases are due, Dr. T. believes—1st. to the smallness of the abdominal incision, in neither case was it more than 5 inches long—the intestines were not exposed to the air and in fact in the last case, not even seen. 2nd, to the mode of securing the pedicle. As in all his operations, Dr. T. employed No. 20 shoemaker's white thread and ligated the pedicle in small segments. Also, the high temperature of the room (about  $95^{\circ}$ ) the atmosphere, being saturated with watery vapor, slightly impregnated with carbolic acid, was believed to have contributed to these favorable results.

Dr. A. L. Smith, then read an interesting paper on the A. C. E. mixture, which he considered the best anæsthetic for midwifery practice.

The A. C. E. mixture consists of two parts of chloroform, three parts of ether, and one part alcohol.

The greatest claim for this combination is its safety. The second is the small quantity required. The third is the ease with which the patient comes under its influence, there being no period of excitement. The fourth advantage is the pleasantness of its odor, not irritating the bronchial tubes as alcohol or ether alone does. And fifth, there is rarely if ever any vomiting after it.

He said that the reasons for the mixture of A. C. E. in the proportions of 1, 2, 3, being safer than any one of its components alone, were as follows: when inhaled in sufficient quantity, alcohol killed by the head, or by coma, chloroform killed by the heart, or by syncope, ether killed by the lungs.

8th January, 1886.

Dr. Roddick in the chair.

Dr. Trenholme shewed a composite ovarian tumor, removed from a lady (aged 21) last Tuesday, the tumor weighed 15 lbs. and was composed of numerous cells, containing a tenacious dark tarry fluid, which would not pass through the trocar. When breaking up the cells, the walls were so friable in various places that the contents of the cyst escaped into the abdominal cavity, the patient was placed on her side, and cyst with the fluid in the cavity were removed, the patient was then put on her back, pedicle ligated, in Dr. T.'s usual way, the abdominal cavity thoroughly washed out, sponged, rewashed and sponged again, and

the incision closed with 5 deep silver sutures. The usual toilet was made, avoiding the bandage (for which Dr. T. has a special aversion) and the patient placed in bed, with considerable apprehension as to the recovery of the patient. The patient made a remarkably good recovery and though the temperature ran up to 100° that night, yet at the end of 36 hours it was almost normal and pulse 80. 48 hours after the operation, I caught her reading a story, and her convalescence has gone on most satisfactorily up to the present time (5 days after operation).

In reply to Dr. Shepherd, Dr. T. stated that he never ligated the pedicle in mass, but in a number of ligatures, enclosing at the most, not more tissue than the size of a goose quill, using always No. 20 shoemaker's white thread.

Dr. R. MacDonnel than read a short paper on hemorrhage into the *pons varolii*.

In the discussion which followed, Dr. H. Howard stated that it was not yet known from what vessel the hemorrhage into the pons was derived. This point yet remains to be determined by some pathologist. Dr. MacDonnel also exhibited the bones of the thigh and leg of a microcephalic idiot. The femur was not longer than the little finger and of very light structure.

Dr. Alloway made some remarks, and shewed a sketch of a case of posterior laceration of the cervix uteri. Nothing new was elicited.

Dr. Blackadder read a paper upon the value of white lead paint in erysipelas in infants. In the discussion which followed, most speakers regarded the local treatment as secondary to constitutional treatment. Dr. A. L. Smith spoke of the value of quinine in gr. doses every three hours, as very useful.

Dr. Trenholme said that he had found elder berry (flowers) tea, thickened to the consistency of cream, the most pleasant and useful of local applications.

#### HURON MEDICAL ASSOCIATION.

The Huron Medical Association held its annual meeting in Seaforth on the 12th ult., and was largely attended. Dr. Taylor, of Goderich, the President, occupied the chair. Dr. Graham, of Brussels, exhibited the stomach of a man who had committed suicide by drinking carbolic acid. He

also read a paper giving an account of a child aged two years, the measurement of whose limbs were different. This did not, however, as yet interfere with the child walking. Dr. Campbell, of Seaforth, reported an instructive case of puerperal eclampsia, in which pilocarpine had been successfully used. He also presented interesting cases of compound fracture of the leg, progressive muscular atrophy, infantile paralysis, also a case of chronic pains following herpes zoster. Dr. Smith, of Seaforth, read an interesting account of three cases of naevus removed successfully with the thermo-cautery. He also presented a paper showing the excellent results which had been gained in three cases of subacute rheumatism, associated with anæmia, by the use of salicylate of iron. Dr. Young, of Londesboro', showed a case of caries of the lower portion of the femur. Dr. Mackidd, of Seaforth, presented notes of a case of tapping of the bladder above the pubes for incontinence of urine, occasioned by an enlarged prostate. He also presented a case of dissecting aneurism. Dr. Gunn, of Brucefield, presented a case of pleurisy with effusion, in which the aspirator had been used successfully three times; also a case of epulis for which an operation was recommended. Microscopic specimens, of the cholera bacillus and several varieties of abnormal urine were shown. The discussions following the different papers were most interesting, and instructive. The following officers were chosen for the ensuing year: *President*, Dr. Campbell, Seaforth; *Vice-President*, Dr. Young, Londesboro'; *Secretary*, Dr. Worthington, Clinton. It was decided to hold the meetings during the year every three months alternately, at Clinton and Seaforth.

#### HAMILTON MEDICAL AND SURGICAL SOCIETY.

The annual meeting of the above named society was held on the 5th ult., a large number of the members being present.

Dr. Stark was elected President; Dr. McCargow, Vice-President; and Dr. F. E. Woolverton, Sec.-Treas.

Dr Shaw reported a case which occurred in his practice, of hæmorrhage from the bowels in an infant. The child was born on the 24th Dec. Labor was easy and natural; child cried vigorously;

visited the patient same evening. On the 26th—50 hours after birth—child passed blood from the anus in considerable quantity, and looked pale and feeble. Nursed on the 3rd and 4th day, but not since. There is a history of phthisis in the family. The child died. The writer quoted from West a number of cases which occurred in early childhood, and gave a synopsis of the cause and treatment recommended. Out of 23 cases 12 recovered. Dr. MacKelcan saw two cases. Family history good, in both; one had a number of discharges and lived only 12 hours; the second case recovered. Dr. Malloch saw a case in Jan., 1880, which terminated fatally.

F. E. WOOLVERTON, Sec.

### Selected Articles.

#### THE PHYSICIAN'S DUTY AS TO PATENTED ARTICLES.

A recent number of the *American Druggist* contains an interesting editorial upon this ethical question. After taking the ground that all those, whether physicians or pharmacists, "whose profession has a direct bearing upon the relief of suffering humanity, should be considered as having renounced the moral right to secure or control patents, on any articles that are primarily used for remedial purposes;" and admitting that a relatively smaller number of pharmacists feel their obligations in this regard than of physicians, the article goes on to consider the important point of the proper relation of those who may use patented articles to those who own the patents. The writer remarks: It is the prerogative of the physician to employ for the cure of disease any method of treatment which he conscientiously believes to be conducive to the benefit of his patient. But it is not only his prerogative, it is even his *duty* to do so, if he knows that favorable results may be expected from the use of some remedy or appliance, even though they be claimed by a particular sect as quasi-proprietary, or else be guarded by a patent. If the physician has the choice between a non-patented and a patented article, he will quite naturally prefer the former, provided it is equally serviceable. But if the latter answers the purpose better, he is perfectly justified in recommending and employing it. The onus of immorality attaching to such a patent belongs to the patentee exclusively, but *not* to the person who uses it or is compelled to use it in want of something equally good and unpatented.

In following this argument, it should always be remembered that a patent implies not merely a

monopoly, but at the same time removes all secrecy from the invention. Every one, therefore, who uses a patented article or invention has full opportunity of examining its details and its adaptability to any special case. The reverse is the case with so-called proprietary medicines, the composition of which is kept secret, and which are copyrighted by title. It is hard to understand how any physician can persuade his conscience that he is justified in using such preparations—the composition of which is at the discretion and mercy of men seeking to make money—in the treatment of the sick.

From the above, it follows that a physician is perfectly justified in employing an article patented by others, provided he considers it of special benefit to his patient. On the other hand, he is not justified in using proprietary "medicines," of unknown composition, the ingredients of which may at any time be altered by the maker without his knowledge. Incidentally, also, it follows that the whole business of manufacturing, selling, or using proprietary "medicines" is unjustifiable, wrong in principle, and indefensible as long as there is any secrecy maintained about their composition.

It is probably known to all who read this that *no product of nature*, whether existing as such ready formed in any of the three natural kingdoms, or artificially obtainable as a definite compound of constant composition and characteristic properties (such as many artificially prepared organic chemicals), is capable of being patented. Only the special *processes* by which such products are reached can be protected by a patent. If another inventor discovers an entirely different process leading to the same result, he is as much entitled to a patent as his predecessor. There are numerous indispensable articles used in medicine which have been at times, and are even now, partly hedged around by patents, but in almost all of these cases the patent does not amount to a monopoly, inasmuch as there are channels left open by which the same article may be procured without an embargo. Take the case of salicylic acid. This may be obtained perfectly pure from oil of wintergreen, and is in fact manufactured from this source for the market. There is no patent on this. But the process discovered by Prof. Kolbe, which enabled the acid to be made at a low price on a very large scale, is protected by a patent. The patented acid is much cheaper and equally pure as the natural. Would any one plead in favor of using the more expensive natural acid, merely because the artificial is patented? Many other such cases might be cited, but the argument in favor of the patented article would remain the same. In like manner it is shown that the new antipyretic, antipyrine, is made under a process that is patented. Its chemical composition and mode of preparation have been announced to the public through the patent publications. It therefore is proper for the physician

to make use of the unequalled antipyretic powers of the drug. Meantime, should another investigator hit upon a different method of preparation, the latter could have the choice either of throwing open the right of manufacture to the world at large, or of protecting his new process, likewise, with a patent.—*Boston Medical Journal*.

### THE CURABILITY OF CONSUMPTION.

In an article on pulmonary phthisis in the *Medical Record*, of the 21st ult., Dr. J. Milner Fothergill, of London, makes the somewhat startling assertion, based on an experience of ten years in a chest-hospital, that the disease is far from being necessarily fatal. Under fairly favorable circumstances, he holds, a rally may be made in the large bulk of cases, which may lead to recovery. This is glad tidings, and a detail of the means through which this consummation may be reached, will be eagerly read. It is customary in acquainting the patient of the fact that he has consumption, to do so in a tone and manner calculated to shut out from him the faintest ray of hope. Treatment, moreover, is usually undertaken with a view to euthanasia, rather than with a hope to snatch the brand from the burning. If, therefore, Dr. Fothergill has put it in our power to tell the consumptive that the odds are in favor of his outliving his disease, he will prove to have been one of the greatest of the benefactors of this and succeeding ages. He does not propose anything particularly new in the way of treatment, nor does he vaunt any specific. His common sense application of means already familiar will, however, commend themselves to the attention of the profession.

The line of attack advised in incipient cases is to improve the general condition, in which improvement the new growth has its share. To check the body expenditure and to increase the body income are our aims. All out-goings must be stopped. This is the first step. If a woman, attend to any leucorrhœa at once. Many a good line of attack has failed, many a woman sunk into her grave who might have been rescued, if only that out-going had been attended to. If the catamenial loss be heavy, put an arresting finger upon it by some ergot, sulphuric acid, and sulphate of magnesia, commencing with this two days before the appearance of the flux, and continuing it during the flow, reverting to the usual treatment on its completion. Then, is there diarrhœa? If so, attend to it. Milk and farinaceous matters are indicated (no meat-broths, no beef-tea—"giving the patient a stone when he asks for bread"—unless some farina be added). Then for medicine some astringent preparation of iron may be given in the day, and a pill of sulphate of copper (gr.

$\frac{1}{4}$ — $\frac{1}{2}$ ) with opium (gr. 1— $1\frac{1}{2}$ ) at bed-time. If there be both diarrhœa and night-sweats this pill will often "kill two birds with one stone."

If there be night-sweats, arrest them at once, or as soon as may be. Sweat is an excretion, and is highly charged with blood-salts. Consequently, profuse sweats are most exhausting. Check them, and the appetite returns, and between the two the patient does well. Prof. Sidney Ringer, F. R. S., has laid the phthisical world under a deep debt of gratitude by pointing out the potency of belladonna in the matter of hydrosis. The best preparation is atropine, not only because it is tasteless, but because we know exactly what we are doing when using it. But to secure its good effects it must be pushed. Its effect upon the pupil is nothing. Indeed, in a very extensive use of belladonna the pupil has rarely been affected. (The effect upon the pupil is a bug-bear which ought to be buried). Dry throat and dim eye-sight are discomforts, but unless severe they need not disturb the treatment. There is a wide gulf between these and any real danger. The very lowest dose is  $\frac{1}{15}$  of a grain. If this does not achieve the desired end, then  $\frac{1}{10}$ . If that is insufficient, then  $\frac{1}{5}$ . If that fails—which it rarely does—one must begin to look seriously at the case. When this dose is reached, and yet the sweats continue, Dr. F. adopts the plan of an old New York quack, of which Lewis Sayre told him, viz., to sponge the body over with hot vinegar ( $\frac{1}{2}$  pint) with a teaspoonful of cayenne in it. This is not at all disagreeable, and is effective. If the combined measures fail, the patient's case is hopeless, but his physician's conscience is clear.

Perhaps the patient's rest is broken by cough. Dr. F. recommends the following combination in such cases: Morphine, (gr.  $\frac{1}{3}$ ), atropine (gr.  $\frac{1}{30}$ ) with pil. galban co. or pil. al. et myrrh., as the case may require. This is a pill which has done him yeoman service in his warfare with phthisis. It has found its way into the Brompton Hospital, and more recently into Squire's *Companion to the Pharmacopœia*. It will, he thinks, find its way before long into every consumption hospital in the world. This action of carbonic acid upon the sweat-glands has led Dr. Lauder Brunton to advocate strychnine (a potent stimulant to the respiratory centre) in the night-sweats of phthisis. No doubt it is useful. Dr. F.'s practice is to give it in the day-medicine. His favorite mixture at the hospital consists of liquor strychnine (4 minims), acid phosph. dil. (15 minims), tincture capsici (4 minims), in infus. gent. (3 dr.), *ter in die*. This forms a capital tonic. Some quinine or sulphate of magnesia (or soda) may be added as required. One of the rules which have formed themselves in his mind is to give acids when the tongue is clean or coated. When the tongue is bare, raw, or irritable, then alkalines are indicated

as am. carb. (gr. 2 to 5), tinct. nuc. vom. (10 minims) inf. gent. (1 ounce), *ter in die*. On such a line of treatment the patient usually improves. The night-sweats cease, the appetite returns, the cachectic look departs, and the patient feels much better. The improvement is maintained, and soon iron and arsenic can be added to the strychnine, and cod-liver oil to the dietary (but cod-liver oil is not the best form of fat, nor yet the most palatable, though it is the most digestible. Some forms of fat in an emulsified state are now on the market which possess many advantages over cod-liver oil). Iron is a good hæmatinic. Arsenic is an alterative and a tonic greatly believed in by many good observers in lung-consolidation. If the patient can be induced to take fat in any form the healthy tissues can be built up. Very commonly the affected area is found to shrink, and air to pass into it. In a few months, in many cases, it is scarcely possible to detect any change in the lung. The threatened danger has passed away!

All along in the treatment advocated the matter of improving the condition has never been lost sight of for a moment. If the patient can get away to a dry soil and a bracing locality, all the better for him or her. Another common patient is the person who has chronic phthisis with cavities. Such patient is always spare and badly nourished at the best; and when any intercurrent ailment still further lowers the general condition the lung trouble is aggravated. (And one matter has forced itself upon his attention, viz., that wherever there is old lung-consolidation any disturbance in the liver sets up irritation in this consolidated patch with resultant cough. And this cough, which is intractable to ordinary cough-medicines, is relieved by acting upon the liver.) The appetite has fallen off and the nutrition is impaired; and then the special danger in phthisis is set up. Very often the tongue is raw, or beefsteaky, or patchy. Here attention to the *prima via* (as our grandfathers phrased it), is imperative. The patient must be sent to bed, to reduce the body expenditure to the minimum. The medicine must be bismuth, with alkalis; and the food, milk with malt extract, or a malt preparation with Mellin's food, in small quantities at a time, oft-repeated. No solid particle in the stomach to vex and irritate the sensitive (because ill-fed) mucous membrane. Even an alkali—like carbonate of magnesia—may be required to neutralize acidity and prevent too firm curdling of the milk: as much as will lie on a sixpence to the half-pint of milk is usually sufficient. Having got the assimilating processes into good working order, the tonic may be given. "The more haste the less speed" is especially true of the treatment of phthisis; and the desire to push on with tonics and good food sadly too often defeats its own end.

Sometimes a masterly inactivity is the wisest practice. A clear head and a firm will are often required to curb the desire of the patient (and still more the patient's friends) to be getting on. Back-cast after back-cast teach a painful lesson to the medical man, and involve the patient in acute danger. If the pressure put on a young medical attendant is becoming more than he can bear, let him call in an older head to help.

The chief thing to avoid is morphia tinctures for the cough. An opiate to procure sleep may be essential and unavoidable; but sedatives in the day are dangerous. They give relief from the cough but too commonly they give permanent relief by death. Opium lays its palsying hand upon the assimilative organs, and destroys the appetite. Its evil effects seem most distinctly felt by the liver. When an opiate is indicated at night it should be combined with ipecac to antagonize its effect upon the liver, and with aloes and myrrh pill to correct its action upon the bowels. Opium strikes directly at the assimilation which is the cardinal matter in the treatment of phthisis. The patient most certain to die, the case least amenable to any treatment, is that one whose wasting progresses steadily, and where the lungs are only affected quite late on—indeed, a brief while before the final change sets in. As to other means of allaying the cough than opiates, inhalations of steam are often serviceable. Friar's balsam, iodine, carbolic acid, terepene, eucalyptus, all are good as additions to steam. Where there is a cavity with ragged walls smelling offensively, a respirator with cotton wool charged with carbolic acid is indicated.

Then, as to the other means of feeding the patient, there are injunctions of oil, often of service, especially with young subjects. Nutritious enemata have only lately suggested themselves; but in one case of a medical man steadily wasting, an enema of cod-liver oil (emulsified by a drop of bile) and milk in equal quantities is being tried. Such enema night and morning, while in the recumbent posture, would be readily retained. When the temperature mounts up, and especially when the skin is also moist (the usual state in hectic fever connected with phthisis), Dr. F.'s plan is to give quinine (gr. 2 to 5) with tincture of digitalis (10 to 15 minims) and dilute phosphoric acid (15 minims,) thrice daily. The effect is very satisfactory usually. Where a severe raking cough is present, shaking the poor sufferer terribly, it may be necessary to give opiates; but, in the author's experience, such cough is very rarely found with pulmonary phthisis.

The treatment of hæmoptysis is quiet; no movement, no talking. When it arises from the bursting of an aneurismal sac in a cavity, or from an ulcerating process eating into a blood-vessel and opening a communication between the vessel and

an open air-tube, syncope alone is likely to arrest it. In congestion of the lung it is often an excellent form of local bleeding. Men of old bled for its relief; now free purgation with a mineral salts is in vogue. For small recurrent hæmoptysis the best treatment is to keep the bowels open. Ice, ergot, and dilute sulphuric acid may also be tried; probably they will do no harm. It is a bad plan to feed up a case of recurrent hemorrhage; it only fills the vessels rapidly, to end in more bleeding. Finally, the management of phthisis pulmonalis, whether the less grave or the more serious conditions, is a good test of the knowledge, skill and tact of the practitioner, who must, like a competent soldier, be able alike to plan a campaign or execute a sudden change of front in an emergency. That is, he must be able to lay down a persisting plan of treatment, and promptly change his plan to meet some intercurrent condition, as hæmoptysis or acute gastric disturbance.—*Med. Age.*

### PLACENTA PREVIA.

Dr. E. G. Edwards, London: In conclusion, I recommended, when head presents, to separate the placenta from the os uteri all around as far as you can reach, if labor has commenced. Then, if possible, detach the placenta on one side completely, so as to allow you to reach the membranes and rupture, to give ergot by the mouth or ergotin by hypodermic injections, and use a little pressure over uterus externally. In most cases as the water discharges the head descends, thereby plugging, by pressure on the placenta, so thoroughly as to check the hemorrhage. I am in the habit of emptying the bladder by a catheter and having forceps on hand, and a roller bandage around the abdomen in order to give external support if required, and holding a plug against the os with my hand if the flooding is severe. I had no occasion to use forceps in any case of placenta previa so far.

Respecting turning, I should, in cross birth, carefully try to turn by manipulation by finger in the vagina and external assistance.

I might here state that I have thus succeeded in cross births, lowering the shoulders, raising the hips and so bringing the head, feet, or breech down. I see no reason why we should not try, especially in cross births, in cases of placenta previa.

My advice is never to introduce the hand through the placenta and thereby gain entrance into the uterus for the purpose of turning, for thereby violence is sure to follow. In fact I am not an advocate for turning by introducing the hand into the uterus under any circumstances, unless all other means fail; as I consider that procedure very injurious to the mother and very apt to be followed by shock or by inflammatory

action of some kind. Possibly in some cases, no other mode is practicable, and it must then be had recourse to. Respecting plugging, I have always succeeded in arresting hemorrhage by this means, giving thereby safety and time. It likewise stimulates the uterus, and the os is found more dilated. I would not give ergot unless I knew the bladder was empty, the parts proportionable, the os dilatable, and instruments at hand. Flooding nearly always relaxes the os. My rule in giving ergot is first to make sure of head, feet or breech presentation, with some pain, and in cases in which I have decided to deliver at once. Ergot would only increase the mischief in placenta previa, unless it was given to assist your efforts at the time of expulsion of the child.

Respecting hot drinks, I am aware that cool or cold drinks are generally recommended in cases of flooding. I do not, however, believe in giving cold drinks in shock or great depression. Opium, in small doses, as a stimulant, I hold very valuable in floodings, and large doses in the cases requiring the plug, to give rest and sleep when time for rallying is necessary.

I am of the opinion, if there has been great loss of blood, that the sooner you deliver the better, provided the hemorrhage continues, and there is pain, and the patient not too weak; but you should not introduce the hand into the uterus if you can possibly avoid doing so, always giving an anæsthetic when you do. I put emphasis on this latter—anæsthetic (ether or chloroform). My practice and advice is, in all severe midwifery operations, to give one or the other. My reasons for thus advising are:

1st. It is humane and prevents unnecessary suffering.

2d. By its use depression and shock are lessened, if not prevented altogether.

Allow me here to say that I, at any rate, have not, neither do I intend adhering to the old traditional theories and procedures respecting the use of anæsthetics in midwifery.

In conclusion, following up turning in cases of placenta previa, the only argument I can conceive justifying it when the head presents, is the speedy delivery of the child in order to save its life, but how often will we be disappointed in this, as it is well known where some floodings have taken place the child is usually born dead. To compensate for that, by plugging and waiting, the shock of introducing the hand into the uterus will be avoided and the maternal parts not injured. I believe the time is not far distant when turning, by introducing the hand into the uterus, will be the exception, not the rule, as at present.

I have adopted a procedure of my own, viz., when called to a case of placenta previa near the end of pregnancy, when flooding is in progress, with the pains continuing and the patient not too

weak or exhausted, to separate as much of the placenta as I can on one side, detaching a portion of it completely from one side, bringing it down into the vagina; and if the os is not well dilated, and the pain continuing, to squeeze the detached portion between my fingers, or to press it firmly against the opposite side until the os dilates: then I give ergot and rupture the membranes, still pressing the detached portion of the placenta until the head descends sufficiently to check the hemorrhage.—*Med. Age.*

### TREATMENT OF ANGINA PECTORIS.

It is a well known fact that all remedies which have hitherto been exhibited against the paroxysmal affections termed angina pectoris have been, generally speaking, failures, and that nearly all patients subject to these attacks have to succumb early to the progress of the disease. Even the latest approved treatment of angina with nitrite of amyl, nitrite of sodium, and nitroglycerine, as discussed some months ago in the *Gazette*, will but rarely, and under certain conditions only, cure or alleviate the affection. Huchard, the famous clinician of the Bichat Hospital of Paris, has recently published a valuable essay (*Journal de Médecine*, No. 3, 1885) which throws an entirely new light upon the pathological agents of the affection and offers important therapeutic suggestions.

A large number of autopsies (thirty five) convinced the author that the ancient pathological views held respecting angina pectoris, as taught as early as 1799 by Jenner and Parry, were fully correct, viz., that the anginal paroxysm is the result not of a neuropathic condition but of an arterial affection. In every instance where post-mortem examinations were made Huchard found ossification, and occasionally even obliteration, of the coronary arteries, conditions which naturally lead to cardiac ischæmia. Again, numerous cases were observed by Huchard and other clinicians in which a well-established cardiac neuritis was wholly disconnected from any anginal symptoms. These observations showed the uselessness of resorting in angina pectoris to remedies which simply act upon the nervous system. The bromides, Huchard says, have never cured a case of angina pectoris save the so-called false anginas, which, among other clinical characteristics, have the peculiarity of being cured by the suppression of the numerous causes productive of them and of frequently disappearing spontaneously without any medication. The cases of genuine angina pectoris belong to the most serious of pathological conditions known, and almost invariably terminate fatally. Hence in any clinical statistics concerning the curability of angina the genuine and false cases are to be strictly separated.

Huchard by his novel treatment, based upon his

undoubtedly correct pathological views, records a greater number of cures of true angina than any other clinician has ever obtained previously (twenty cures). His treatment consists principally in the exhibition of iodides, which, as is well known, are alone able to cure the affections of the arterial system, even those of a non-syphilitic nature. The iodide of potassium or, better, of sodium, given without intermission for months, and even years, in a daily dose of 1 to 2 grammes (15 to 30 grs.), will with certainty at first diminish the frequency and intensity of the anginal procyms, and finally bring about their definite and complete disappearance. The curative effects of the iodides of sodium and potassium in aneurism of the aorta and various other arterial affections show the powerful influence of the iodide treatment on pathological conditions of the vascular apparatus.

In aortitis, both of the acute and chronic type, we find most frequently dilation of the aorta and elevation of the subclavian artery. Under the influence of the iodide treatment both symptoms can be relieved promptly and permanently. The most refractory cases in regard to this treatment are those in which the aortitis and the arteriosclerosis approach their termination, for the iodides, however powerful they are cannot suppress an arterial atheroma. In general, it can be said with propriety that "the iodides are the digitalis of the arteries." Huchard's routine formula is,—

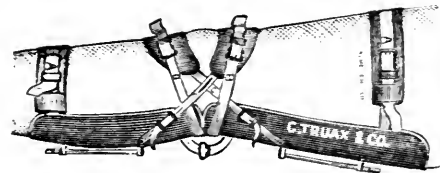
R Sodii iodidi, . . . . . gr. cl;  
Aque destil., . . . . . f. 3℥.  
Fiat sol.

S.—Two to four teaspoonfuls daily, to be taken in a cup of tea.—*Therap. Gazette.*

### A NEW PATELLA SPLINT.

Dr. L. R. Markley of Juniata, Neb., sends us the follows description and cut of an apparatus designed by him:

"I desire to call the attention of the profession to a splint designed principally for the treatment of transverse fracture of the patella, but which I believe will also be found useful in cases of frac-



ture of the limb at or near the knee joint, and in many cases of dislocation. A few years ago, while yet a student, I conceived the idea of making a splint as here illustrated, and as I have had made for me by Messrs. Charles Truax and Co., 81 Randolph St., Chicago. This splint consists of two



well padded iron troughs shaped to fit the limb above and below the knee. These troughs are connected with an adjustable hinge having a circle stop which will permit the splint being applied and firmly held either straight or flexed at any desirable angle. It can thus be used straight in treating fractures of the patella, or bent to meet the requirements when used in other cases. The two screws shown underneath the brace can be turned by a removable thumb-key and are attached to sliding heads running in slots cut in the troughs. To these heads are attached the straps C C which places the amount of traction on the patella completely under the control of the operator. Underneath these straps are placed two well fitting pads which hold the patella in its proper position. The bands B B are made use of to prevent the pads from slipping too far over the patella. The bands A A hold the extremities of the splint firmly to the limb.

In applying the splint the bands A A and B B should be first adjusted; then after tightening the straps C C (using the buckles), traction can be made with the thumb-screws until the edges of the fractured bone are brought together. If, however, the ligamentum patellæ is too strong to be overcome by this measure and thus prevents a complete reduction of the fracture, I believe it would be safe to perform at least partial tenotomy of the ligament and thus render its reduction by this method possible. Whether or not the pressure of the pads will cause sloughing in some cases I have not been able to determine, for in a country practice cases of this kind are seldom met with.

I have had several surgeons examine the splint and they all believe the principle to be a good one.

I have not had the opportunity to make a practical test of the splint since I had it made, and in presenting it to the profession I hope that some one who may deem it worthy of a trial, and having an opportunity of trying it, if not for a fracture of the patella, some other accident at or in close proximity to the knee, will report the result."

TREATMENT OF PALMAR GANGLION.—The *Lancet* June 27, 1885, lays down the following rules for treatment of palmar ganglion, as in accord with, the best and most recent views of surgical authorities on the subject. The first point of importance is to attempt the cure of the cases as early as possible. No good can come of delay, which merely leads to greater distension of the cyst, and is especially to be deprecated as endangering the adjoining tendons, which become stretched, and even in some cases severed, by the pressure to which they are subjected. Second, the free evacuation of the cyst and the removal of all the "melon-seed bodies" it contains, whether these be free in its interior or adherent to its walls. For this purpose an incision about an inch and a half long, not a

puncture, should be made in the most prominent part of the swelling, above the annular ligament, avoiding, of course, the radial vessels and the tendons, which can be felt through the skin. Pressure should be made in the palm to force out the fluid and as many of the loose bodies as will thus escape. Then a sharp spoon should be introduced, and the whole cavity scraped, to detach any "bodies" which may be still fixed to the synovial membrane. The "spoon" is much the best means of doing this. Some have trusted to injecting a fresh stream of fluid into the cyst, but this will not remove "bodies" which are still firmly adherent to the cyst-wall.

Volkman passes a large drainage-tube through the cyst, and draws it sharply to and fro, and trusts to that to detach any adherent "bodies;" this is, however, an uncertain method, and if the cyst be old and large, with pouches extending from the main cavity, they escape the friction of the tube altogether. Having thus carefully removed all the contents of the cyst, whether solid or fluid, a solution of chloride of zinc, 40 grains to 1 ounce, should be applied to the whole interior of the sac, the purpose of this being so to modify the nutrition of its lining as to prevent any recurrence of the dropsy. A solution of iodine has been used for the same purpose, and some surgeons may be inclined to use iodoform instead. The most important steps in the treatment are those to be taken to secure healing of the wound without suppurating, at any rate without septic suppurating. As a preparatory step the parts must be thoroughly cleansed before the incision is made, and the operation should be conducted under an antiseptic spray or irrigation, and some efficient antiseptic dressing should be finally applied. A drainage-tube should be introduced into the wound and passed down beneath the anterior annular ligament, and only removed when the discharge through it is reduced to a minimum.

Dr. Weiss shows that if pressure be carefully applied over the palmar part of the cyst, all retention of fluid can be carefully obviated. The hand should be kept fixed on some kind of splint applied to the extensor aspect, until the wound inflicted is healed. As soon as that is accomplished, the fingers should be liberated and the patient be encouraged to move them. The results of this treatment are entirely different from those formerly met with. When the antiseptic precautions are carefully carried out, there is no danger whatever of blood-poisoning or of profuse local suppuration, and the final result is the restoration of a thoroughly useful hand. The tendons are not bound down by cicatricial bands, and after a time it may be impossible to find any trace of the previous mischief beyond a linear scar in the forearm. Weiss considers that the process of cure of the synovial cyst is analogous to that obtained in a

hydrocele by injection, or in dropsy of a joint treated by injection of iodine. At present no case of a recurrence of the ganglion after a septic incision and drainage has been reported.

**IMPROVEMENTS IN EXCISION OF THE KNEE-JOINT, AND LIGATURE OF LARGE ARTERIES.**—Mr. Edward Thompson says on this subject: There are some points in the treatment of excision of the knee-joint, both at the time of operation and subsequently, which seem to me to deserve particular attention. I have had a good many of these cases under treatment from time to time in the Tyrone Infirmary; and the suggestion I have now to make, and which I desire shortly to detail, are the outcome of my experience.

In the first place, I always make the first incision nearly straight across the limb, and as small in extent as possible; with one sweep of the knife the ligamentum patellæ is cut through, and the joint opened. The upper end of the ligament is then seized and dissected off the bone, and the patella removed. The subsequent steps of the operation require no comment. When the bleeding has ceased, the cut surfaces of bone are placed in close apposition, and the divided ends of the ligamentum patellæ are strongly stitched together with carbolic silk; the skin-flaps are brought together in the usual manner, and the wound closed, no drainage tube being inserted. The limb is at once put up in plaster-of-Paris, with a back splint of strong hoop-iron; another strong piece of iron is bent over the situation of the wound, so as to allow the application of the proper dressings: two side-splints of hoop-iron, about eighteen inches long, and slightly hollowed over the wound are placed lengthways, across the site of the joint, and over the plaster-of-Paris, the whole being firmly secured by a bandage. A completely rigid and comfortable bed is thus secured for the injured limb. The upper and lower portions of the limb are padded with French wadding, and, close to the wound, with carbolic tow. If there be any discharge from the wound it will penetrate the tow, which can be readily removed and replaced without disturbing the limb. I have heard a great many discussions, and read a great many elaborate articles, on the proper method of treating these cases: but, as yet, I have seen no apparatus which is so easy of application or so reliable as the plaster case I have attempted to describe, and which is coming into very general use.

The chief points I wish to emphasize are—1, the small extent of the primary wound really necessary; 2, the preservation of the ligamentum patellæ, not by its non-division, but by the divided ends being stitched together; 3, the enormous anterior support afforded by the preservation of the ligament, and the lessened tendency to displacement; 4, the increased power given to the limb by

preserving almost intact the insertion of the powerful crureal muscle; 5, that stitching the patellar ligament seems quite as efficacious as the recommendation by some authors of its non-division; and that, while effecting subsequently the same purpose, it in no way hinders, or renders more difficult, excision of the joint.

In all my recent cases of amputation of the thigh, I have tied the femoral artery with a strong carbolic silk ligature, and cut off both ends short. The wound has healed, and remained healed, in every case. Thus a troublesome cause of irritation—one end of the ligature being left hanging from the flap—and a very great impediment to the healing of the flap-wound by first intention, has been effectually got rid of.—*British Medical Journal*, Nov. 7, 1885.

**DISEASES OF THE PLACENTA AND CORD DUE TO SYPHILIS.**—The following are the conclusions of Dr. Saxinger of Tübingen, concerning this affection:

1. There exists a placental syphilis, which, in a fair proportion of cases, is recognizable on microscopic examination.

2. Placental syphilis generally accompanies fetal syphilis. It is also found in maternal syphilis with a healthy child.

3. The placenta may be diseased in an isolated lobe and throughout its density, or solely in its fetal portion, or its maternal portion.

a. If the mother has been infected by the fecundating coitus, with the fetal syphilis, the placenta is found to be more or less diseased throughout. Ordinarily, the umbilical vessels themselves are diseased.

b. If the mother is not infected, generally, besides the fetal syphilis, only the fetal placenta and the cord are diseased. Nevertheless, the morbid process may extend to the maternal placenta, and infect the mother by intra-uterine repercussion.

c. If the mother has been infected some little time before conception, if the mother has been fecundated by a healthy man before the outbreak of general symptoms, and if she has undergone treatment during pregnancy, a healthy child may be born to her. Here the maternal portion of the placenta is generally the only one diseased.

d. If the mother has been infected some considerable time before the fecundating coitus, ordinarily it is the placenta alone which is diseased. Under the influence of the progress of the morbid process, the fetal placenta and the whole of the placenta may be involved in turn, and the fetus participate in the infection, if indeed, from the disturbance of the circulation, it is not destroyed.

e. If the mother is fecundated by a healthy man, and if she is not infected until later, in spite of the immunity of the fetus, the placenta is al-

way diseased, however slightly. When the mother is syphilitic, the placenta does not escape, unless the mother be infected at a period very near to her time of delivery.

4. It is not proved positively that a woman can be infected by the passage of a syphilitic child through the genital organs, nor that a child can be infected during delivery.

5. Experience shows that children conceived during the first years of acquired syphilis, or badly treated syphilis of the parents, die during intra-uterine life, or are born non-viable. A mercurial treatment, which is well directed, may interrupt this transmission at all periods, or maintain a condition that is latent for years. If syphilis remains so latent in an organ, it is possible, after appropriate mercurial treatment, to see healthy children born, and later syphilitic children.—*Archives de Tocologie*, June, 1885.

**LEAD POISONING AMONG SEWING MEN AND WOMEN.**—Dr. Arthur V. Meigs, of Philadelphia, Physician to the Pennsylvania Hospital, has a note under the form of "a clinical lecture" on this subject in the *Medical News* (November 21st, 1885), with the title of "An Unusual Cause of Lead Poisoning," which should attract attention. As he entered the waiting room of the ward, he noticed a man seated upon a bench, looking very pale, and with an expression of great pain upon his face. He said he had violent pain in the abdomen. As he protruded his tongue for inspection, his breath had a heavy disagreeable odor. He had had no passage from his bowels for five days, and had been constipated for some time past. There was also upon both the upper and lower gums, the characteristic blue discoloration of lead poisoning. The man said he was a tailor, and had not done any other sort of work for a long time. Nothing could be learned tending to show that his drinking water was in any way contaminated, and he strenuously denied using any leaden implement or handling the metal in any shape. Later, the Doctor was told that Dr. H. C. Wood used to relate in his lectures at the University of Pennsylvania, that he had attended sewing women suffering with lead poisoning contracted from biting thread, which it was found was weighed with sugar of lead. Upon asking at a large tailoring establishment in Philadelphia, Dr. Meigs was told that much of the sewing silk used now-a-days is treated with sugar of lead to give it the desired weight; and then the Resident Physician, Dr. Penrose found in the *Half-Yearly Abstract* for 1866 (from July to December), an article by M. Chevalier, giving an account of how thread was treated with lead, and how women using it suffered from lead poisoning. The patient under consideration undoubtedly had the disease from the use of thread which had been treated with sugar of lead.

Dr. Meigs finished his lecture by advising the use of morphine to relieve pain; then Epsom salts to relieve constipation; and then iodide of potassium to eliminate the poison from the system.

This record has an important suggestive bearing in general practice. It is not altogether improbable that some of the cases of constipation and agonizing abdominal pains met with in sewing women and tailors are due to just such a cause. The *colica pictonum* is sufficient to awaken the suggestion of lead poisoning in such persons, although there be no blue line along the gums, wrist drop, etc. It is a very common habit for sewing persons to bite off the threads they use and keep portions of them in their mouth to chew on as a quid. Family physicians in their talks to families about household hygiene should keep their patients warned about such a possible result of improperly using threads; and in doubtful cases of persistent constipation, with abdominal pain, resembling *colica pictonum*, it would be well to resort at once to iodide of potassium, along with remedies to relieve pain and constipation. We are satisfied that in our professional rounds we have seen cases that would have been more speedily relieved by such measures than by the vacation plan of treatment which we have advised, under the impression that the trouble was due to sedentary habits, leaning forward in cramped positions, etc.—*Virginia Med. Monthly*.

**FRACTURE NEAR A JOINT.**—Dr. Coskeny contributes an article in which he shows that the signs of fracture ordinarily laid down in the books, namely: crepitus, deformity, and mobility are practically useless when the bone is broken near a joint. For these he proposes to substitute the signs: fixed pain, the site and quantity of hemorrhage, and perfect helplessness of the limb. He says:

"We will take up and describe each of these signs. It often happens, as for instance in fractures of the fibula alone, that we can observe no *deformity*, *crepitus*, or *mobility*, but, if we follow the line of the fibula up, at one certain point, the tip of the finger elicits pain. If this is always complained of whenever pressure is made upon this point, I think the diagnosis is plain. The pain is evidently due to the soft parts being irritated by the sharp edges of the fractured surfaces.

"The second of these signs, the *site* and *quantity* of the hemorrhage should be considered thus: my patients fell striking upon the *outer* side of the limbs, and ecchymoses slowly made their appearance on the *inner* side, and then in considerable quantity. Had the bleeding been the result of contusion alone, it not only would have appeared sooner, but at the point injured. As it was from the small and noncontractile vessels of the bone, the bleeding was longer in progress than it would

have been in the soft parts, where very probably a larger vessel would have been ruptured. Again, during this slow bleeding, the blood had time to gravitate to a dependent position, or direction of easiest escape. But in my own opinion, the absolute helplessness of that portion of the limb that contains the broken bone is probably the most important of these signs. The fact that a patient has not made a step after the accident, or raised his hand above his head, is a strong point to start from in attempting a diagnosis. (I am aware that persons are said to have taken a few steps after having met with an impacted intracapsular fracture of the femur, but this has nothing to do with the point under consideration).

"There is one mistake that I have several times seen made in diagnosing fractures of the femur. When the patient is told to raise his thigh from the bed he can do so by contracting the hamstring muscles, sliding the heel upon the bed, and thus the lower end of the femur is pushed up by the head of the tibia; but the *psoas-magnus* and the *iliacus* do not contract. For fractures in the continuity of the long bones these signs are, of course, of no use, but for those in which difficulty of diagnosis so often leads to mistakes in diagnosis, I think the presence of one or more of them should suggest to us the probabilities of a fracture, and should indicate to us the proper plan of treatment."

—*N. W. Lancet.*

**HABITUAL ABORTION AND KIDNEY DISEASE.** — At the recent meeting of German scientists and medical men at Strasburg, Dr. Fehling, of Stuttgart, read a memoir on habitual death of the embryo in kidney disease. In the first case under his observation, premature expulsion of a dead fœtus, occurred six times, and there was no evidence of syphilis. At every pregnancy, anasarca, albuminuria, and death of the fœtus, with severe cramp of the abdominal muscles, occurred, between the fifth and sixth month; the dead fœtus was expelled from three to ten weeks later. In the second case, similar symptoms appeared in a young unipara; the fœtus died, and thereupon the albuminaria abated. In the third case, the patient had borne two healthy children. During her third pregnancy, albuminuria and characteristic changes in the retina occurred; and, during the fourth, she was seized with hemiplegia; in both, a decomposed fœtus was expelled at the fifth month, with subsequent decrease of the albuminuria. In the fourth case, the patient in her first pregnancy aborted at the fifth month; then she gave birth at term to a recently dead child. In the third pregnancy, great œdema and albuminuria supervened, the child was stillborn, and the mother died of uræmia. Dr. Fehling believed that in all these cases, kidney disease existed before pregnancy, which aggravated the renal symptoms.

Winter had described two cases of premature detachment of the placenta, normally situated, where albuminuria existed. Dr. Fehling found atrophy of the villi of the chorion, with wedge-shaped or spherical infarcts in the placenta, in his cases, similar to renal infarcts. The infiltration of the chorionic villi and vessels of the umbilical cord with small cells, as seen in syphilis, was absent, nor did any of the embryo exhibit a trace of congenital syphilis. — *British Medical Journal.* November 21, 1885.

**THE TREATMENT OF CHOREA.**—In a paper on this subject, presented to the Harveian Society, of London, Dr. W. B. Cheadle, after referring to the failure of innumerable specifics, and to the skepticism too widely engendered therefrom, declared his own belief in the value of medicinal treatment. Speaking from the careful notes of one hundred and sixty cases observed during a period of eight years, he stated that the average duration of the disease under treatment had been five weeks (the extremes being ten weeks and four days); whereas cases without treatment might extend from eleven to fifty-two weeks, or indefinitely. The author had tried various methods, including rest and expectancy, with results sometimes beneficial, but never completely successful. In arsenic, he had at last found an agent which did succeed. Todd, as long as forty years ago, had recognized its power: so had Babington and Begbie; but dread of the poison had checked their use of the remedy. Dr. Cheadle proceeded to narrate some striking cases of rapid improvement under the influence of ordinary doses of liquor arsenicalis, with small doses of tincture of perchloride of iron. A comparison of long series of cases treated without arsenic and with arsenic respectively, gave for the former an average duration of forty days, for the latter, twenty-nine days; and this difference was increased when the last fifty-eight cases were compared with fifty-eight consecutive cases in the former series, the average duration under arsenic being only twenty-four days. Arsenic was in every case well borne, excepting a remarkable result repeatedly observed by the author, but not hitherto described by others, viz., a bronzing of the skin analogous to that observed in Addison's disease. The staining was most masked in the flexures, did not affect the face, and ultimately disappeared. In one case, however, it had become permanent, but would probably vanish in time. The pigment deposited was not metallic, as in discoloration by silver, but resembled the pigmentation due to chronic congestion. In conclusion, while advocating arsenic in chorea, the author did not wish to depreciate the value of other therapeutic agents, which should be employed concurrently.

**STRYCHNINE IN DELIRIUM TREMENS.** That the

tremor, so characteristic of cases of chronic poisoning by alcohol, is greatly benefited by the persistent use of strychnine, which, by the way, is the most efficient remedy for this very ailment, has long since been recognized as a well-established fact. But that the same drug also is a powerful remedy for an attack of delirium tremens, has been less known, though occasional mention has been made of the fact. We learn from the *Deutsch. Amerik. Apoth. Zeit.*, vi. 9, page 277, that Dr. Journet, of Lyons, has recently treated such a case, where he employed subcutaneously over one and one-half of a grain of sulphate of strychnia within forty-eight hours, without having given rise to any symptoms of poisoning. Further, Dr. Lardi re, who a short time ago demonstrated the fact that strychnine was the best and perhaps only true antidote in alcoholic poisoning, published but a few weeks ago another case, that of a man,  t. 42, who presented all symptoms of delirium tremens, as, history of debauch, tremor, redness of the face, hallucinations, sleeplessness, etc. Within four days this patient received nearly  $4\frac{1}{2}$  grains of strychnine therefore, an enormous dose, with the result that a rapid improvement took place, and by the end of the fourth day a complete recovery set in. Within the first twenty-four hours the pulse fell from 124 to 90, as the effect of one grain of strychnia. The drug must be given hypodermically, and seems to be specially indicated in cases of weak heart. *Med. and Surg. Reporter.*

**DIPHTHERIA.**—Dr. I. J. M. Goss writing to *Eastern Med. Jour.*, concludes as follows:

The treatment must be very rapid at the outset, which is the only hope of success. In mild cases which may get well themselves, the chlorides of iron, and potash have been used with apparent success, and so of some other remedies, but to cure a case of the more grave type, the best antiseptics must be given at the start, and constantly continued to the end of the attack. Where the disease is from a systemic poison, or inoculation, yet the local manifestation must also be met by appropriate local means, as a spray of permanganate of potash, 4 to 6 grs. to the  , used every one or two hours; or a saturated solution applied with a pencil brush as often. And between the times of using the above, the throat may be touched with a brush or swab dipped in equal parts of alcohol and spirits of turpentine.

Internally, the patient should take 1 or 2 grs. of sulphide of calcium every two hours, and alternate that with the tincture of baptisia tinctoria. If no improvement be manifested in twelve or twenty-four hours, then give 1 to  $1\frac{1}{2}$  grs. of the permanganate of potash every two hours, in alternation with the sulphide of calcium, and have the tonsils and palate sprayed with a solution of the compound tincture of iodine, say 1 part to four of

water, every one or two hours, and at the same time if the lymphatic glands are affected, the ointment of iodine should be applied to them three times a day. If these remedies then fail, the child's throat should be touched with the tincture of eucalyptus globulus every two hours, and 10 to 15 drops given in *sweetened water*, every two hours. Equal parts of iodide of potash, and the chloride of potash is used by some writers, and with good results, say 1   of each, to 6   of water, dose 1   every half hour, so that the throat will come in contact with the solution and the system become saturated with it as soon as possible.

**QUINIA BY INUNCTION.**—Dr. Wm. W. Moore, says in *Peoria Medical Monthly*: About one year ago I was called to see two children, one five and the other seven years of age, both suffering with malarial fever of a remittent type. I prescribed calomel and podophyllin in small doses every three hours until free catharsis was induced, alternating with liberal doses of quinia. The little five year old boy took his medicine without any grumbling, but the combined force of her parents, supplemented by the nurse's and my own efforts, failed to make the little seven year old girl swallow the medicine. While thinking about the advisability of a blister sprinkled with quinia, the thought obtruded itself, "Why not try inunction?"

Calling for some lard, I incorporated a large quantity of quinia with it, at least three or four times as much as I should have given her in twenty-four hours, with directions to rub one-eighth of the mass thoroughly every three hours over the abdomen and inner surface of the thighs. I should have stated that the symptoms in the little girl were of far greater severity than those of her brother. I left promising to be there at the same hour the next day.

Judge of my surprise, when upon my return, I found the patient without fever and getting along nicely. I prescribed the same treatment for the next twenty-four hours. I found her little brother with fever yet, although the remission was well marked. I went back on the third day and found the little girl convalescing rapidly, while the little boy, who continued to take his medicine *per oram*, ran on until the fifth day before his fever "broke." I have had occasion twice since then to resort to the same method, each time with like result, although not quite so promptly.

**NERVE SUTURE, WITH IMMEDIATE RESTORATION OF FUNCTION.**—One of the most remarkable results of the suture of a nerve ever reported is given by Surmay, in the *Archives G n. de M decine*, for Oct., 1885. The case was that of a man who had received a cut above the wrist, resulting in abolition of the function of the median nerve. For some time no attempt had been made to correct

the defect. Then electricity was tried without result. Six months after the accident, Surmay resected about three-quarters of an inch of the nerve, and joined the cut ends with a fine carbolized catgut thread, which had been ingeniously inserted before the intermediate portion was cut out. The function of the nerve was reëstablished within twenty-four hours! The parts which had before been affected—the second phalanx of the thumb and the two terminal phalanges of the index and middle fingers—were found to have wholly recovered their general and tactile sensibility; while the sensibility to pain and temperature had returned in the thumb and in the upper half of the phalanges of the other fingers involved. Complete restoration followed after several months.

This remarkable case furnishes a strong support to operative interference in other cases than those in which loss of function results from traumatic division of a nerve; for in this one the nerve was not found divided, but the part under the wound was occupied by an enlargement which was formed by pure hypertrophy of the neurilemma. It is always surprising that the cicatricial changes which must take place in, or immediately adjacent to, a resected nerve, should have so little effect in disturbing the result of the operation. In the case mentioned, it seems to have had some disturbing influence, although this passed off with time. Further, this case is interesting as raising questions in physiology which will bear close study, namely, as to the reinstatement of one part of the function of a nerve while another remains in abeyance, as well as in regard to the relation of the different forms of sensation, which are commonly divided into: common sensation or sensation of pain, and the tactile sense, which includes appreciation of changes in temperature. As Surmay's case seems to have been studied with great care, and to present many of the conditions of scientific accuracy, it may contribute materially to our knowledge of the physiology of the nerves. *Med. News.*

**FUNCTIONAL IMPOTENCE.** DR. ULTZMAN'S TREATMENT.—The two forms of this affection which present themselves most frequently for treatment are: 1st, Psychical impotence; and, 2d, Impotence from too early ejaculation of the seminal fluid. They occur usually in strong, healthy young men, and are the forms which yield readily to proper treatment. The treatment is almost entirely local, as the difficulty consists in the incapability of having a normal erection. The capacity of exciting erections resides in the prostate; hence, this is the point to which treatment is to be directed. This is of several forms, all calculated to relieve the hyperæsthesia of the prostatic urethra, and excite the prostate to the production of powerful erections. The simplest form of treatment is by

passing a steel sound into the bladder daily, leaving it there from five to ten minutes, at the same time depressing the handle so as to make pressure upon the prostate. Usually, in a few days or weeks, powerful erections are excited. The use of astringents upon the prostatic urethra is another method. The remedies used are either tannic acid or the solution of nitrate of silver. Tannic acid is inserted in small slender suppositories by the *porte remède* and deposited in the prostatic portion. Urine should not be passed for half an hour after the insertion. This treatment may be used every day, and not less frequently than every second day, till normal erections occur. Nitrate of silver is used in a five per cent. solution, and three or four drops deposited upon the prostatic portion by a deep urethral syringe, once every three or four days. During treatment, the patient should abstain from all sexual excitement. — *Engl. Med. & Surg. Jour.*

**THE USE OF ANTIMONIALS IN PNEUMONIA AND INFLAMMATION.**—D. Leith Napier, M.D. (*Practitioner* for September), states that while children do not bear the antimonials as well as adults, the following "mistura scillasalina" has proved of great utility (sometimes combined with a suitable dose of belladonna or hyoscyamus) in the febrile catarrhal condition attending dentition:

*Saline Mixture.*

R Liq. antimonii tart.,  
Spts. ætheris nitrosi, aa fʒijj;  
Liq. ammon. acet., fʒij;  
Aquam ad fʒviiij.

M.

Fiat mistura.

*Squill Mixture.*

R Vin. ipecac.,  
Vin. antimonii, aa fʒij;  
Syr. scillæ, fʒij;  
Aquam ad fʒviiij.

M.

Fiat Mistura.

These mixtures may be given alone, the first being more generally employed. In some cases the squill mixture is given alone, as in the latter stages of pneumonia; but, as a rule, equal parts of each were used.

The benefits of antimonials are more evident in pneumonia than in other inflammations; but, while Dr. Nias (*Practitioner* for August) follows Trousseau in giving comparatively large doses in the stage of engorgement (not hepatization), Dr. Napier treats the first stages with salicylic acid, antipyrine, or quinine, reserving the antimony for the stage of resolution, except in cases marked by low stamina and great debility. — *Med. Times.*

**CONCENTRATED SOLUTIONS OF SALINE CATHARTICS IN DROPSY.**—Dr. Matthew Hay, of Edinburgh (who has accepted a chair at Johns Hopkins



University), presented a novel method for the treatment of serious effusions in the *Lancet* (April, 1883), the good results of which have been recently reaffirmed by Dr. W. G. Eggleston (*Four. Amer. Med. Assoc.*, March, 1885). In cardiac dropsy, or pleural or abdominal effusion, abstinence from water and liquid food is enjoined for one day, and on the following morning a comparatively large dose (three ounces) of magnesium sulphate dissolved in two tablespoonfuls of hot water is to be administered. The results which have been reported have been surprising, especially where the saline is repeated on the second morning. Large watery evacuations are obtained, and the effect may be enhanced by the subsequent use of jaborandi (ext. fld. twenty drops), to act upon the skin. This method of treatment deserves further trial by the profession, not forgetting, however, that in children or persons subject to bowel-disorder a serious entero-colitis might be developed. Christison reported a case of a boy who took two ounces of Epsom salt and died with symptoms of gastro-enteritis without purgation. The hypodermic injection of solution of magnesium sulphate has been advocated in cases of dropsy.—*Med. Times*.

**MERCURY AND ALBUMINURIA.**—At the congress for internal medicine, held at Wiesbaden in April, 1885 (*L'Abeille Medicale*), Dr Fürbringer reported that he had found, out of a hundred chosen cases, eight syphilitics with perfectly healthy kidneys who developed albuminuria during mercurial treatment; the maximum albumen being five per cent.

The internal and external exhibition of the mercury was followed by the same results, which persisted during the whole of the treatment and disappeared some weeks after treatment was stopped.

The alterations in the kidneys were therefore not important, as was proven as well by microscopic examination.

In another series of one hundred cases of syphilis which had not been treated with mercury, or were no longer so treated, and in which the kidneys had been healthy, he was able to establish in twelve per cent. an albuminuria consecutive to the syphilis.

This in every case was discovered in the stage of the roseola eruption. Here the urine contained formed cylinders, which pointed to a light nephritis. This form of albuminuria gave way to mercurial treatment. Therefore he argues that the existence of albuminuria is not a contra-indication to mercurial treatment, which, on the contrary, should be prescribed as a necessity.—*Journal Cut. and Ven. Diseases*.

**STEPHEN SMITH'S AMPUTATION AT THE KNEE-JOINT.** At a recent meeting of the Royal Medical and Chirurgical Society, London, Mr. Thomas

Bryant read a paper on amputation at the knee-joint, and reported thirty cases. The author strongly advocated disarticulation by the method of Dr. Stephen Smith. He exhibited illustrations of the operation, and endorsed completely the remarks of the American surgeon upon the value of his method of procedure, and strongly urged its application to cases of amputation in the leg also. The muscle substance was generally included in the flap in thin subjects, but not in others. The resultant stumps in the leg thereby obtained were excellent. As compared with other methods mentioned, Mr. Bryant stated that the method of Dr. Stephen Smith was to be preferred, as it gave a better covering to the condyles of the femur, and the flaps were less prone to slough; it also placed the cicatrix entirely behind the condyles, out of the way of injury, permitting no bagging of fluids, the stump being in the best position for drainage.—*Lancet*, Dec. 12, 1885. [This operation was performed recently in the Toronto General Hospital, in the case of a railway injury to leg, by Dr. Fulton, with most excellent results. Almost the whole of the resulting cicatrix occupied the intercondyloid notch, and was thus entirely out of the way of pressure in wearing an artificial limb.]—Ed.

**ERUPTIONS DUE TO THE USE OF CERTAIN MEDICINES.**—Quinine: Erythema scarlatina; papular erythema; hemorrhages and purpura; pemphigus, oedema, and prurigo. Cinchona, Belladonna, Stramonium, Strychnine, have the same characters as quinine. Digitalis: Erythema after long use. Aconite: Vesicular exanthemata. Santonine: Pemphigus, vesicles. Opium and Morphine: Erythema; papular eruption, with marked desquamation and itching. Pilocarpine: Increased perspiration. Atropia: Diminished perspiration. Phosphorus: Purpura. Mercury (internally): Erythema; eczema. Arsenic: Erythema and papules; vesicles and pustules. Carbolic acid: Erythema; pemphigus. Salicylic acid: Purpura; vesicular angina, pemphigus. Chloral: Erythema, slightly colored, itching, desquamation; purpura and petechia; eczema. Copaiba, Cubebs, Turpentine: Pemphigus, erythema, eczema. Cod-liver Oil: Acne. Iodide of Potassium: Papules, vesicles; pustules, ecchyma, eczema; ecchymoses and purpura. Bromide of Potash: Papules and pustules, deep tubercles with ecchymoses, pemphigus, ulcers.—*Translated by Dr. C. E. Warren in College and Clinical Record*.

**LEUCORRHOEAL DISCHARGES FROM ROLLER SKATING.**—Dr. Von Klein writes thus to the *Boston Med. and Sur. Journal*:

"Mrs. L. consulted me about two of her little girls, Anna, aged ten, and Eva, aged twelve years. The mother called my attention to a leucorrhoeal discharge which she lately observed on their cloth-



ing. An examination of the parts verified the mother's statement. I told her I could not account for it, as I had already seen it in children younger than hers, but the lady, who is of rather extraordinary intelligence, advanced a theory that their recent excessive indulgence in roller-skating brought on their affliction. Certainly, I partly coincided with her sentiments. When she returned home and spoke to other ladies about the matter, it brought out the fact that there were many others afflicted in the same way. In fact, I examined nine children in forty-eight hours, whom I found affected with leucorrhœa. These children were all roller-skaters, from nine to sixteen years of age. Their mothers steadfastly maintained that they were not afflicted before they commenced the so-called exercise. I have reason to believe that the practice of roller-skating exercise is injurious to young females by reason of excessive movements of the lower extremities, especially of the pelvic organs, including the walls of the vagina. I trust the profession everywhere will record cases of this nature that may come under their observation, which will, I am sure, reveal many valuable pathological changes caused by the exercise of roller-skating."

**MEDICAL NOTES.**—Many of the patients applying for relief at the out-door department of the (Woman's Hospital, Baltimore), complain of vesical irritability, frequency of micturition, with burning pain at the meatus and much straining. In a large proportion of these cases the urine is alkaline and frequently cloudy. These symptoms are usually quickly relieved by the following combination :

R. Acidi benzoici, ʒj;  
Sodii biboratis, ʒss;  
Aque, - f5vj. M.

S.—Tablespoonful every three or four hours.

If the trouble does not yield to this medicine. Dover's powder in three-grain doses every two to three hours is frequently found effective.

As a tonic in the anæmic condition so often attendant upon the pelvic troubles of women, the following pill is given :

R. Quininae sulphat., gr. xlviii;  
Ferri sulphat. exsic., gr. xxiv;  
Strychninae sulphat., gr. i. M.  
Ft. pil. xxiv.

S.—One after each meal.

The operations for lacerated cervix are generally done in the hospital without an anæsthetic. A catgut loop is passed around the cervix and drawn tight by means of a wire-ecraseur frame. This not only renders the operation a practically bloodless one, but the strangulation of the tissues obtunds the sensibility, and the denudation can be completed and needles passed without causing more than a slight degree of pain.—*Med. Times.*

# HYPODERMIC INJECTION OF DEFIBRINATED BLOOD.

—Dr. Oscar Silbermann, of Breslau, has published an account of two cases of severe anæmia which he treated successfully by the subcutaneous injection of defibrinated human blood. The first case was that of a little boy of eight, who, after measles and whooping-cough, became very anæmic, there being a systolic mitral murmur, vomiting, and fainting fits. Iron and other drugs were tried and proved useless, so forty grammes of defibrinated human blood were injected under the skin of the thigh, and a rapid improvement resulted. The injections were, therefore, repeated, and the child was completely cured. The second case was that of a girl of eleven, who had been reduced to a highly anæmic condition by profuse bleeding from a rectal polypus. There were in her case, as in that of the boy, a systolic mitral murmur, vomiting, and fainting fits. Fifty grammes of defibrinated human blood were injected subcutaneously into the thigh, and rapidly brought about a cure. The author remarks that the greatest care must be taken to disinfect the hands, the instrument, and the cutaneous surface, both of the patient and of the person who gives the blood. The blood must be completely defibrinated and kept at a temperature of 39° C.; also, during and after the injection, the surface should be rubbed or stroked in an upward direction.—*Lancet.*

**THE DANGER OF VACCINATION SHIELDS.**—In his capacity of medical officer to the Local Government Board, Dr. Buchanan has issued a caution against the use of vaccination shields. Cases of erysipelas have been traced to their use, and, having regard to their construction, is by no means difficult to understand why such results should have followed. That portion of the framework of the shield which rests on the arm, as also the bands for fastening the apparatus on, are covered with, or consist of, porous material, such as lint, &c. : and whenever any discharge takes place, this material runs almost certain risk of being soiled. Any subsequent use of the shield practically, amounts to the use of a dirty surgical dressing, and it is well known how serious a danger this is, even to the most trivial of surgical cases. Protection for a vaccinated arm is rarely wanted in the case of an infant, for the arm can easily be altogether taken out of the clothing, care being taken to wrap the child up warmly in some loose shawl or other similar article which is free from irritative dye. Having regard to these considerations, vaccinators are urged to discourage the use of so-called "vaccination shields," and to advise some other means of preventing irritation by means of clothing, where this may be necessary. —*Lancet.*

**SHOCK AND ITS TREATMENT.**—In a critical study of shock intended to elucidate its pathological relations, Groninger, of Berlin, defines shock as an

exhaustion of the medulla oblongata and the spinal cord produced by violent excitation. This definition is no doubt perfectly proper, though it strikes us as if the term "exhaustion" is not sufficiently clear for defining purposes.

He recognizes the following varieties: 1. The lowest grade of shock, which causes no appreciable effects. 2. A middle grade, which weakens sensation. 3. A high grade, which extinguishes qualitative sensation. 4. A highest grade which eradicates both passing and permanent sensations of every kind.

His views of the treatment are noteworthy: Energetic counter-irritations of the skin are to be excluded as useless and even dangerous. Abstraction of blood is contraindicated. Transfusion of blood can only be thought of in cases of great loss of blood. Opium and chloroform are of no value whatever in shock, while digitalis is worthy of further study. Alcoholic stimulants and subcutaneous excitation are useful. Horizontal posture, application of warmth, perfect rest, and subcutaneous injection of strychnine are the most recommendable factors of treatment.—*Therap. Gaz.*

**ARTIFICIAL MEMBRANA TYMPANI.**—Dr. Barth, of Berlin (*Archiv für Ohrenheilkunde*, Bd. xxii. p. 208, August 12, 1885) has suggested a very good modification of the ordinary cotton-wool membrane, as follows:

Take a piece of cotton-wool, and pull or twist out one end of it to the length of four centimetres, leaving a tuft at the other end. The handle thus made should now be dipped in collodion, and the whole, supported by means of the tuft through the mesh of a cane-seat chair, allowed to dry. In the course of five or ten minutes the handle or shaft should be again twisted, best with moist fingers, and there is then provided a strong shaft of cotton-wool one to two millimetres thick, with a brushlike tuft, which can be further trimmed by the scissors as required. This artificial membrane is so simple and so easily made that every intelligent patient can make it for himself if he is obliged to wear such an aid for any length of time. *Med. Times.*

**CRAVING FOR STIMULANTS.**—To counteract the craving for stimulants, when they are withdrawn, and to sustain the nervous system, the following combination is effective (Bartholow):

R Tinct. capsici.....f. ʒ vj.

Tinct. nucis vomice.....f. ʒ ij. M.

Sig.—Twenty drops, in water, every four hours. *Col. and Clin Record*, Oct.

**ASTHMA.** Dr. Q. C. Smith, of Austin, Texas, writes: To relieve those desperate paroxysms of asthma that threaten life every moment until re-

lieved, I am accustomed to administer hypodermically the following:

R Mur. pilocarpine,

Apomorphia each.....gr. ʒ.

The patient will quickly sweat profusely, breathe easier, and obtain sleep within ten minutes. —*Gaillard's Med. Jour.*

**CHLORAL IN ALBUMINURIA.**—Dr. Burduzzi, (*Il Movimento*) has obtained excellent results with chloral in daily doses of thirty to forty-five grains, continued for some time in the treatment of nephritis. Under its use œdema is reduced and the albumen nearly or entirely disappears from the urine. The author regards it of especial value as a prophylactic of eclampsia in the albuminuria of pregnancy. It is also useful in the so-called physiological or normal albuminuria.—*N. Y. Med. Record*, Sept. 19th.

**CONNECTION BETWEEN AFFECTIONS OF THE EYE AND SPINAL CURVATURE.**—A Polish physician, Dr. Jarsinska, has traced a connection between errors of refraction and curvatures of the spine. In thirty-seven cases of curvature, he was able to prove with certainty the previous existence of those or other abnormal conditions in the eyes, such as insufficiency of the internal rectus, astigmatism, asthenopia, etc. Myopia alone, however, does not appear to cause curvature. Unequal vision and insufficiency of the internal recti seems to be most efficient in the production of spinal curvature. Spasm of the accommodation also is capable of producing it. Removal or relief of the eye affection is followed by improvement in the spinal curvature—a troublesome and obstinate class of cases in orthopædic practice.—*Lancet*.

**ARSENIC WITH QUININE IN THE TREATMENT OF MALARIA.** Dr. Ernst Hensler, of West Franklin, Ind., warmly advocates combining arsenic and quinine in the treatment of malarial fevers. He says that his residence in the Ohio bottom lands has given him a wide experience in this class of diseases. Like so many other physicians, he formerly used either quinine or arsenic alone, and often without success; but latterly he has been in the habit of giving the two drugs at the same time. Since commencing this practice, he states, all his cases were rapidly cured and no relapse occurred.

**BLOOD-LETTING IN ERYSIPELAS.**—Dr. Daniel Lizzaralde, of Buenos Ayres, stated that he has seen most excellent results following the abstraction of blood in facial erysipelas. The procedure is indicated in the case of a strong, full-blooded adult, when the temperature is high and the cerebral symptoms are threatening.

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

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TORONTO, FEBRUARY, 1886.

*The LANCET has the largest circulation of any  
Medical Journal in Canada.*

## TREATMENT OF PNEUMONIA.

We do not wish to convey the idea that we have anything new to offer regarding this very common and fatal disease. For the very reason that it is common and fatal, it should be kept before the profession. Moreover, the treatment as outlined in our text books, is extremely vague, and for the most part unsatisfactory, especially to the young physician, who has not the experience which will enable him to follow any particular line of treatment with confidence, being perplexed by the conflicting statements of some of our most reliable authors. Discussion will tend to the discovery and fixation of the theories and practices about which there may be a general uniformity of opinion. The benefit to be derived from a free interchange of thought, was well expressed long ago by the wise man who said, "as iron sharpeneth iron so does the countenance of a man his friend."

Since the "heroic" was abandoned for a more humane and rational mode of treatment, but little progress has taken place. Additions and subtractions more or less important have been made, it is true; still we have made no very marked advance. This statement is borne out by the fact, that we have been lately drifting a little back to some at least, of the old practices, a tacit acknowledgment that the profession has been carried a little too far out on the wave of reform. At a recent society discussion, grey-headed veterans confessed with sorrow, that whereas they formerly

bled too often they now do not bleed often enough, one of them confessing to not having opened a vein for twenty years. It is now almost universally conceded that venesection is a proper, lawful and beneficial remedy in selected cases. Antimony, especially in England, is generally administered in acute cases in small and repeated doses. Blistering once so fashionable finds but little favor. It is a severe and painful agent, needing careful handling. It is quite possible to kill a healthy person with a large blister. This is now so well understood that there is no danger of a re-action in favour of that adjunct in general treatment. A very small blister limited to the seat of pleuritic pain, may still be regarded as permissible. So much for the re-action in favor of old remedies.

The treatment which took the place of the heroic, some thirty years ago, may be called the expectant-supporting treatment. The better results obtained were not so much due to the practice being uniformly correct as to the fact of its being better than the one it supplanted. Results still better are now obtained from pursuing a middle course. While admitting that the tendency of disease is towards a lowered vitality, yet we now controvert the theory that disease is always best combated by a supporting and stimulating treatment. In the case of acute pneumonia, experience has clearly demonstrated the value of remedies classed as depressants. On the other hand, it is distinctly held that such remedies are inapplicable to asthenic cases. From this it would appear that the lines of treatment are pretty well agreed upon, and that the points of divergence have reference to the best means of fulfilling the accepted indications.

If we do not yet understand fully the nature and cause of the disease, we know well what its manifestations and tendencies are. The first aim of all treatment is the arrest of the morbid process, and failing that, to carry it through its course to a successful issue. We do not now often see the word "inflammation," formerly so freely interspersed in discussions on diseases. On the theory that the blood was the seat of the inflammation, the old treatment aimed at curing the disease by draining off the blood. But this had the disadvantage of frequently carrying off the patient. With a better understanding of the nature of the disease came a more rational explanation of the use

of the lancet. No one contends for indiscriminate bleeding. No one even contends for bleeding in a typical case. This potent remedy in our armamentarium is only to be used in extraordinary emergencies. That such emergencies do arise is painfully evident from the large number of sudden deaths, due to this disease. Should we be called to see a robust patient, more or less suddenly prostrated by pneumonia, temperature high, pulse full and rapid, great dyspnoea, the right side of the heart staggering under the blockade, the proper thing to do is to bleed at once and bleed freely. Of course the blood is the patient's capital, still, to save his life, he must part with some of it. That will raise the blockade, equalize the circulation, promote suspended organic function, and give a fresh starting point.

No well informed physician now denies the marked beneficial effects of venesection in suitable cases; yet how seldom is the remedy resorted to! How account for this discrepancy between theory and practice? In cases scarcely demanding venesection, antimony is probably the best agent to rely upon. Early in the case, perhaps, no harm is done should temporary nausea be produced, but care must be taken not to prolong that condition. Given in this way it reduces arterial tension, induces perspiration, and promotes the secretions generally. Care must be taken not to keep up a too free and continued action of the skin, that being both disagreeable and exhausting. While no harm can come of the use of small repeated doses of antimony, continued through the acute stage, yet, the *average* case can hardly be said to call for it. Here veratrum, with liquor ammonia acetatis, or some such remedy, seems to supply what is wanted, namely, as in all such cases, the relief of blood pressure by equalization of the circulation. This end is generally well and satisfactorily fulfilled by the above combination. The veratrum should be given in such doses as to produce the desired end. Let the dose, and the frequency of its administration, be deliberately decided upon in each case, and let the pulse be carefully watched. Venesection makes its results manifest at once, and herein perhaps lies one of its chief merits. In the use of substitutes we should keep this object steadily in view. The patient should be brought as rapidly as is consistent with safety, under the influence of the remedy. To do this, the

physician requires the aid of an intelligent nurse, should the patient reside at a distance. Much mischief is done by a slipshod treatment. Let medicines be administered with care and precision and better results will follow.

Opium is a most important adjunct in the treatment of acute pneumonia. We are aware that some are opposed to it on theory, but we are convinced that in this case, as in many others, experience contradicts theory. Nothing tends more to recovery than freedom from suffering and a tranquil mind. Nevertheless opium is inadmissible in a number of cases. It must be withheld when the heart is overweighted and the block in the lungs extensive. When the disease arrives at the stage of expectoration, it is well to remember that opium may do harm by restraining exudation. At a later stage, ammonia, senega, and digitalis may all be necessary and are the best of our second class of remedies.

So far our remarks refer to cases of asthenic type, occurring in persons of good constitution. No greater difficulty can be imagined than that arising from shades of difference in cases met with in practice, in all diseases. This is one reason why medicine demands the very highest order of intellectual power. Text books are poor guides in individual cases, and often almost all depends on the knowledge and good judgment of the attendant. The semi-heroic treatment, if we be allowed the expression, above outlined, is not applicable to asthenic cases occurring in the feeble and unhealthy. In such cases the second, or stimulating class of remedies, will be called for from the outset. Here too we would remark that remedies should be administered in their proper therapeutic doses—neither too small nor too large—neither too seldom nor too often. Let us decide exactly what we are to do and act promptly on this decision.

Perhaps we should not close without some matters of routine. We need say no more about extensive blistering. That is deprecated on all hands as a piece of painful barbarity, which cannot fail to counteract the tranquilizing effects anticipated from our other remedies. Since the abolishment of cantharides—hot linseed poultices have been very extensively used, and we have the highest authority as to their beneficial action. The French jacket poultice is the best, indeed by

this simple means the patient is really "bled into his own veins," the blood pressure in the heart is reduced, the heart is stimulated by the heat, and the blood which, as we before said, is a part of the patient's capital is conserved for future need, when perhaps the powers of the system are strained to the last point of endurance. No doubt when the temperature is high, the practice tends to check radiation, but this disadvantage is small when compared with the relief obtained by its use. The question of using an anodyne liniment having slight counter-irritant action has been raised, to avoid this addition to the body heat, but remembering the words of Rindfleisch, that moist heat is what is required, we do not think that the liniment would fulfil so useful a purpose as the poultice.

The question of treating pneumonia by large and repeated doses of quinine is as yet *sub judice*, though several men of experience have reported very favourably as to its action. We hope to present to our readers some of the conclusions of the profession in this matter, in the near future.

#### A FIELD FOR OUR ANATOMISTS.

A clever writer in one of our English magazines some months ago undertook the task of attempting to describe man as he would be some thousand years hence, after having undergone all the various changes brought about by the gradual "adaptation to environment"—to use scientific phraseology. The author came to the conclusion that man in after ages would be a hairless, toeless animal, incapable of extended locomotion, and with a head abnormally large. The data from which he argued are easily recognized: the wearing of hats and boots, and the large amount of time spent in pure brain work are the chief.

By some the article was considered to be merely a travesty on the theory of evolution. By others it was thought to be a true but over-estimated account of the practical workings of that theory. In whatever light regarded, however, the paper contains many suggestions, interesting, not only to the evolutionists and biologists, but especially to enthusiasts in the study of human anatomy.

Whatever views may be held on the doctrine of the descent of man, it is a matter of every day

experience that morphological and physiological changes are created by "adaptation to environment." Nor are these changes by any means limited to the lower animals. Perhaps, indeed, owing to his greater activity and dispersion over the whole globe, these changes are greater and more apparent in man. This it is which makes the subject interesting to the general biologist, and consequently to the medical man. Let us glance at a few of these changes; and, for sake of example, let our view be limited to the professional and upper classes.

These classes devote a large portion of the twenty-four hours to reading. In process of time this must give rise to many more or less minute anatomical peculiarities. There will be a tendency to myopia, since the lens will contract a habit of remaining fixedly abnormally convex. The external and internal recti muscles will be enormously developed. And for this reason: in perusing a page of a book or a column of a newspaper, the eye travels from left to right and back again several hundred times, while the superior and inferior recti act but once or twice.

Again, these classes lead a comparatively sedentary life. The gluteal muscles consequently being imperfectly nourished, will tend to gradual atrophy. The tuberosities of the ischium, too, may change in form.

Violent exercise being rare, the respiratory muscles will degenerate. Man will become short-winded, in fact. Already there is a vast distinction in this respect, not only between man and the lower animals, but also between different tribes of men—between the average American young lady and a North American Indian for example. The increasing use of vehicles will hasten such changes in the gluteal and respiratory muscles.

Owing to the fact that so many actions are performed by the right hand alone, not only will mankind become more generally one-handed, but, as a consequence of this, the left side of the cerebellum should preponderate in size over the right. This may in time appreciably alter the shape of the cranium. Perhaps the upper extremities and the head will cease to be bilateral.

These are but a few isolated instances of changes which must undoubtedly be gradually taking place in a single class of men. It would be interesting to extend the enquiry further: to examine, for ex-

ample, the effect of various descriptions of skilled manual labor upon the artisan class; of the mode of life in factories upon mechanics; of the outdoor life upon laborers; and so on.

That the transformations are minute and extremely gradual, is, of course, true; but it is to such small and slow-moving tendencies (added to climatic influences) that the wonderful differences between races have been brought about. The nymphae and the nates of the South African women famed for the large size of these parts doubtless owe their existence to some such processes. It is but scientifically correct to expect anatomical abnormalities to occur. And if anatomical, then, too, physiological. Their practical import is naturally at present almost *nil*; but to the physician and the surgeon of some centuries hence they will not be so. And the physician and surgeon of some centuries hence will perhaps thank us of this generation for having noted changes which will explain to him otherwise inexplicable facts—as the astronomers of the nineteenth century owe much to Chinese annals written some thousands of years before. A thorough and exhaustive view of this subject extended to all the races of mankind, and including every phenomenon which in any way acts upon the human frame may bring to light very many various and important facts hitherto unknown. That this is partially recognized is seen by the careful, accurate and minute investigations yearly prosecuted by the Anthropological Section of the British Association. We are not aware, however, that this Section has paid any particular attention to the group of changes to which we have above adverted. Here is an excellent field for our anatomists.

### CHEYNE-STOKES RESPIRATION.

In Cheyne-Stokes respiration, named after the observers, whose name it bears, and who first described it, we have a form of dyspnoea characterized by a peculiar rhythmical change in the breathing. After a period of apnoea lasting from ten to forty-five seconds or more the respirations commence, at first very shallow—so shallow as to be perceived with difficulty, but gradually they increase in depth and rapidity, till the breathing is loud and violent, the breast heaves and the nostrils are dilated. In some cases the patient now suddenly

rouses, perhaps with an exclamation, has an excited and anxious look, which soon gives place to a placid expression; the patient usually dozes off again, the respirations grow weaker and shallower, until eventually they cease altogether. After a period of apnoea, they begin as before and the cycle of phenomena is repeated. In cases where the patient does not rouse at the acme of respiration there is a gradual decrease as before, ending in the cessation of the respiratory efforts.

This symptom is regarded as a most serious one, being almost always followed by a fatal issue of the disease which occasions it. It occurs in uræmia, organic heart disease, especially in fatty degeneration; certain cerebral affections, as tubercular meningitis, lesions which involve the respiratory centre, etc., etc.

Goodhart draws attention to a modified form of Cheyne-Stokes breathing often observed in infants, which has not at all the same diagnostic import as in adults. He regards it as a paroxysmal type of respiration—at one with the paroxysmal manner in which children perform many of the ordinary acts of life. A nervous discharge occurs—then a pause, another discharge and so on. As the nerve centres reach a high state of training they work more regularly and the discharges are more or less continuous.

Various theories have been advanced to account for this form of breathing, none of which can be considered satisfactorily to make clear why it should occur in certain forms of heart disease, though it may be easily understood why irregularities of breathing should follow lesions of the medulla, affecting the respiratory centre. There seems to be a scarcity of information on the subject, but few autopsies having been made with a view to clearing up the pathological condition giving rise to this symptom. While we have no sufficient accounts of the lesions observed, one or two cases have been reported in which the nervous lesion was located. In one case where Cheyne-Stokes respiration had been observed but a few days previous to death, the pathological change was observed in the upper portion of the bulb, and both pneumogastrics were healthy. This is delightfully vague. In another, the vagi were found diseased, the left but slightly at its periphery, while in the right nerve, the lesion extended into the bulb. At the same time the medulla was the seat of con-

siderable changes, chiefly just above the longitudinal furrow of the calamus scriptorius.

Among the various theories which have been advanced to account for the symptom, the best, though at the same time the most complicated, is Bramwell's. He, following the teaching of M. Foster and others, supposes, that the inspiratory centre consists of two portions, one accelerating and one inhibitory. He further believes that these two portions are acted upon in opposite directions by the blood, whether arterial or venous. Thus while venous blood stimulates the discharging cells of the centre, and depresses the inhibitory portion, arterial blood acts in exactly the opposite direction. He also supposes the accelerating or discharging portion to be in a state of "irritable weakness." Now, at the close of a period of apnœa, the discharging portion is stimulated by the supply of venous blood and at the same time the inhibitory portion is depressed thereby. Hence though the respiratory apparatus has been on what may be called the "dead centre," respiration commences, and increases in force until the blood is fully oxygenized. Now, however, the inhibitory portion is stimulated and gradually overpowers the discharging portion, it being in a state of "irritable weakness," and soon worn out. The respirations grow weaker and weaker until at last the inhibitory portion gains complete mastery, and apnœa results.

This theory does not satisfactorily account for the weak shallow respirations at the commencement of the cycle. Would it not be more probable, that, with the blood loaded with carbonic acid, and the inhibitory portion therefore greatly depressed, the discharging portion, stimulated by the impure blood, would cause explosive breathing, lasting with decreasing strength until the blood was fully oxygenized?

Dr. Sansom believes there is a condition of partial paralysis of the respiratory centre, which thus requires a large amount of carbonic acid to stimulate it to action. This is furnished by the period of apnœa; respiration then commences and increases until the blood becomes fairly purified, when owing to the less amount of stimulation the respiratory centre gradually ceases to act and the breathing comes to a standstill. The theory advanced by Filehne, that a deficient supply of oxygenized blood produces a contraction of the arterioles

of the body—and of course of the medulla—through the action of venous blood on the vasomotor centre would account for the phenomena observed; but what is the primary condition of the centre which renders it abnormally weak? Why does it not perform its function? Why is there a period of apnœa by which the blood becomes loaded with impurities with which to stir up the sluggish centre? Here Bramwell's supposed "irritable weakness" comes in, but after all the point to be decided is, what is the pathological condition of the respiratory centre, or of the vagi which lies behind the first development of this symptom? Until that has been more clearly made out no amount of theorizing will, it seems, be able to make plain the cause of this peculiar form of respiration.

PASTEUR FORESTALLED.—"While exploring the Kalahari," said Mr. Farini (From the *Pull Mall Gazette*,) "where extremely poisonous snakes abound, several cases of the nude natives being bitten by them came under my notice, and, strange to say, the untutored savage, although not knowing anything about *similia similibus curantur*, cure themselves by inoculating with other virus. There is not a native nor a hunter that does not carry either the dried body of a deadly poisonous reptile called the N'ambo, the poison sacs of the puff adder, yellow cobra, or capella. Their *modus operandi* is this:—As soon as possible after being bitten they make slight incisions close to where the poison fangs entered, into which they sprinkle some of the dried and powdered virus. The first effect is to induce sleepiness, the swelling soon goes down, and in a day or two they are as well as ever. Three of my oxen were bitten, and cured by inoculation. One case of the bushman who had cured the oxen I must specially mention. He boasted of not being afraid of being bitten. One day while walking ahead of the waggons I discovered a full-grown capella lying under a bush. I called the bushman and asked him to catch it if he was not afraid of being bitten. He replied he would if I would give him a roll of tobacco. I refused not wishing to be accessory to his death. While I was waiting for the driver's whip to dispatch the snake, the bushman gave the reptile a kick with his bare foot, and the horrible thing lit him. But the bushman coolly took from a little skin



pouch some poison sacs, cut a piece off and reduced it to powder, pricked his foot near the puncture, which had commenced to swell, and rubbed the virus powder in. One of the other bushmen who had killed the snake and extracted the poison-cysts, handed one of them to him: he squeezed a drop of poison out of it into some water and drank it; he seemed to fall into a kind of a stupor, in which he remained for some hours. At first the swelling increased rapidly, but began to subside after some hours. Next morning he inoculated himself again; that night the swelling had completely disappeared and the fourth day he seemed as well as ever, and claimed the roll of tobacco." Mr. Farini took the precaution to bring home the poison of several snakes and a portion of a Nanboo, which he is sending to M. Pasteur to experiment with.

**PERMANENT DEAFNESS CAUSED BY SALICINE AND QUININE.**—The *Lancet* draws attention to the fact that permanent deafness may be caused by the continued use of large doses of quinine and salicine.

From experiments made by Kirchner on cats and rabbits, it appears that hyperæmia and exudation in the labyrinth, semicircular canals, and cochlea follows the administration of quinine.

He mentions also the case of a woman who had an exudation into the tympanic cavity after the prolonged use of salicylic acid, which he removed by performing paracentesis of the membrane tympani. It is stated by Schilling that the combination of ergot with salicylate of soda prevents tinnitus in the great majority of cases. The borate of quinine has been shown by Finkler and Prior to be less liable to produce quinism than the muriate. It would certainly appear as though the salt was to blame for these cases when permanent deafness follows hyperæmia and exudation in the labyrinth, but the disease for which the salts were used may have played a part in the production of the anatomical change on which the loss of hearing depends.

**ONTARIO MEDICAL ASSOCIATION, COMMITTEES.**—The President, Dr. Tye, has named the following gentlemen as members of the respective committees:

*Medicine*—Drs. Gillies, Caw, Hunt, Geikie. *Surgery*—Drs. Atherton, Stark, Throill, Elliott, Gilpin. *Obstetrics*—Drs. Eccles, McDonald, (Hamilton) Brouse, A. H. Wright, Roseburgh. *Ophthalmology*—Drs. Palmer, Reeve, Ryerson, Burnham,

Roseburgh. *Necrology*—Drs. Fulton, Harrison, Wishart. *Papers, &c.*—Drs. Sheard, Graham, Edwards, Hillary, Walker. *Ethics*—Drs. Holmes, McLean, Moorehouse, (London), Mullin. *Audit*.—Drs. Oldright, Teskey, Yeomans. *Arrangements*.—Drs. Temple, Wright, White, W. H. B. Atkins, Pyne, Sheard, Powell, Roseburgh. The subjects chosen by the chairman in medical surgery and obstetrics, respectively are:—*Pneumonia, Fractures of the thigh, and Puerperal Albuminuria.*

**PRESENTATION TO DR. MEWBURN.**—The Medical profession of Winnipeg have presented Dr. Mewburn, late Hospital Surgeon, with a gold watch and chain, valued at \$150, accompanied with an address expressive of the high esteem in which he was held by them. He was also presented with a gold-headed cane by the students of the Medical School. We are glad to notice these kind courtesies from members of the profession towards each other.

**WOODSTOCK MEDICAL ASSOCIATION.**—The second annual meeting of the above association was held in the President's office on the 5th ult. Officers for 1886, Dr. L. H. Swan, President; Dr. J. C. Thrace, Vice-President; Dr. G. W. A. Ross, Secretary and Treasurer. The association is in a flourishing condition; many papers of interest having been read during the past season.

**ABORTIVE TREATMENT OF TYPHOID FEVER BY MERCURY.**—The *N. Y. Medical Journal* gives Kalb's method of treating typhoid fever by mercurial inunction. The inunctions should be undertaken before the ninth day, when he says, defervescence takes place in a few days. The inside of the thigh is chosen for the frictions, which should be continued for half an hour each time. To counteract the damage to nutrition it is advised to use large quantities of alcohol.

**ELECTRO-THERAPEUTICS.**—Those interested in the subject of electro-therapeutics, or the apparatus for its application, are requested to correspond with Dr. A. M. Roseburgh, Toronto.

**CORRECTION.**—Readers of the *Lancet* will please make the following correction in Dr. Aiton's article of last month. Page 130, 1st column, 19th line, from top—"cross lesion," should have been *gross lesions*.

**REPORTING CONTAGIOUS DISEASES.**—Dr. Can-niff wishes to call the attention of the profession of Toronto to the requirements of the Public Health Act with respect to reporting cases of contagious diseases. This should be done promptly and every question answered. Any practitioner not supplied with blank forms can obtain them on application, stamped ready for mailing.

Dr. Lewis (*Medical World*, September) gives the following as his prescription for sexual debility.

R. Phosphori. . . . . gr. i.  
Ext. Nucis Vom., . . . gr. x.  
Ext. Cannabis Indicæ, . . gr. v.—M.  
Div. in pil. no. xx.  
Sig. One night and morning.

**CORONERS.**—Dr. J. A. McArthur of Port Elgin, Ont., has been appointed coroner for the County of Bruce; and Dr. S. Scott of Lloydtown, coroner for the counties of York and Simcoe.

**BRITISH DIPLOMAS.**—Dr. J. B. Lawford (McGill) has been admitted to the Fellowship of the Royal College of Surgeons, Eng.

#### ROBERT DOUGLAS, A.M., M.D.

We deeply regret to announce the death of Dr. Douglas, of Port Elgin, Ont., Vice-President of the Ontario Medical Council, on the 24th ult., at the age of fifty years. He had been in failing health for several years past, but his death was in the end somewhat sudden and unexpected. Two years ago he went abroad for the benefit of his health and returned much recuperated and resumed his practice, but the improvement was not permanent. The doctor was educated in Queen's College, Kingston, and received the degree of B.A. in 1851 and M.D. in 1856. He was elected to the Ontario Medical Council for the Territorial Division of Saugeen and Brock, in 1880, and re-elected in 1885, so that his death creates a vacancy in the Territorial Division and at the Council Board. He practiced many years in Port Elgin and possessed in a high degree the confidence of the profession and the public. His loss will be greatly felt by those who knew him intimately, and his family and friends have our deepest sympathy in their great affliction.

#### Books and Pamphlets.

**PSYCHIATRY.** *A clinical treatise on diseases of the forebrain* by Theodore Meynert, M.D., Vienna, translated by B. Sachs, M.D. PART I.—The Anatomy, Physiology and Chemistry of the Brain. New York: G. P. Putnam's Sons.

As the title of this book indicates, it is intended for the specialty of alienism. The paper is very good and the type will not hurt the eyes even of aged readers. It would be a pleasing duty to award equal commendation to *all* the illustrative plates, no less than sixty-five in number. The reader whose eyes are not of microscopic power, will do well to provide himself with a suitable magnifying glass to enable him to discover the lettering on a few of the above, which though probably very accurate likenesses of the original preparations, have certainly gained nothing in the way of clearness at the hands of the American artist. If the plates 27 and 28, for example, are faithful reproductions of the Viennese artists work, the misfortune must be ascribed to the inappropriate colouring method employed by the author. As the book will be sought after chiefly by psychiatrists, a class of men whose patience is severely enough taxed by the unavoidable perplexities of their vocation, it is a pity that any impediment should be encountered by them, in their laudable efforts to acquire a better knowledge of the anatomy of the brain. It would be perilous to assert that a certain or uncertain minority of their body are already so thoroughly versed in cerebral anatomy and physiology as to stand in no need of further enlightenment. Meynert's descriptions of the constituent parts of the brain, and of their structural and functional relations, cannot fail to be studied with much profit, not only by the imperfectly informed who may muster courage to master the task, but also, and perhaps still more, by those who have made the subject a favourite and prolonged occupation. Let it not, however, be taken for granted, that the great Austrian specialist has reached the Ultima Thule of cerebral science. Readers who may have cultivated acquaintance with the productions of the experimental scientists of other countries, outside of Austria and Germany, cannot fail to see that Meynert would have benefited by a larger intimacy with outside psychical literature. Not in a single instance, in the present volume, has he

named an Italian writer, and it is beyond all question that had he given to the works of Tamburini, Golgi, Luciani, Seppilli, Bianchi and numerous others of the grand old peninsula, even a trifle of his time, he would have produced a still better treatise. Of English writers he *names* but five, and these do not come forth from his pen with much éclat. Of Ferrier, he makes short work, in the following sinistral by-slash. "In parenthesis be it said, that Ferrier's "centres" have met with opposition from *all* other quarters." The italic *all* is Meynert's. It is certainly a *multissimum in parvulo*, but it will not extinguish Ferrier. That his *centres* have been criticised and usefully qualified by several distinguished experimentalists, is well known to readers of foreign medical literature, as well as of English, but that they have met with opposition, in the sense of repudiation or negation, is very far from fact. One can understand why an Austrian Professor could not afford to know something of the doings of a people from whose confines the troops of his own country were ignominiously driven, but what have the English done to merit his scorn? If we may judge from a straggling passage in his preface, Meynert intends in his next volume to annihilate the doctrine of inherited insanity. This will do much in vindication of the mental soundness of his antecedents. Perhaps the translator may be responsible for the following curious announcement. "The brain, like a fixed star, does not radiate its own heat; it obtains the energy underlying all cerebral phenomena from the world beyond it." That Meynert is not a fixed star of this order, will not, by his readers, be questioned, unless the "world without" means only Austria and Germany. But we did not before know that the "fixed stars" do not radiate their own heat. Perhaps Dr. Sachs will not object to a little transposition in the above brilliant metaphor, and allow us to read, "the brain does not like a fixed star, radiate its own heat." If so the author and his translator may claim their proper locations either in the planetary or the cometary range.

THE PEDIGREE OF DISEASE—Six lectures by Jonathan Hutchinson, F. R. S. on Temperament, Idiosyncrasy and Diathesis. New York: Wm. Wood & Co. Toronto: Vannevar & Co.

This book has the two-fold merit of not being large and of coming from the pen of a distin-

guished teacher, whose name will no doubt serve as an adequate guarantee of its utility. Its dedication to the memory of Charles Darwin will hardly fail to commend it to the respectful attention of the general medical profession, and though the veteran practitioner of the healing art may not find in it much that will be new to him, he will be pleased to find some familiar facts presented under a clear and attractive form, and not the less interesting because of his long acquaintance with them. In his observations on *idiosyncrasy*, though the author does not lapse into that hygienic phrenzy which the inspiring subjects of eggs, tea, tobacco, stale fish and alcohol might reasonably have aroused, yet he has perhaps indulged in less twaddle than is usually inflicted on admiring audiences. It is certainly a matter of no trivial regret that so eminent and so experienced a writer has disposed of such important, and sometimes formidable, substances as chloroform, the iodides and bromides, arsenic and some others, with inexpedient brevity. As, however, he was addressing the president and members of the Royal College of Surgeons, he may have been restrained by tender considerations, from enlarging on topics involving delicate affinities. The confession of other people's sins, in mistake for our own, is the cheapest and meanest of human virtues.

J. C. Draper, M.D., LL.D., Professor of Chemistry in the Medical Department of the University of New York, died on the 20th of December in the 51st year of his age.

### Births, Marriages and Deaths.

On the 20th December, James Jagu Hillary, M.D., of Jamaica, W.I., formerly of Uxbridge, Ont., aged 48 years.

On the 14th ult., R. Ramsay, M.D. of Orillia, aged 44 years.

On the 17th inst., John E. Galbraith, M.D., of Bowmanville, aged 34 years.

On the 23rd ult., J. W. Byam, M.D., of Campbellford, Ont., aged 38 years.

On the 27th ult., C. Leggo, M.D. of Ottawa, aged 69 years.

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## Original Communications.

### REPORT OF AN OUTBREAK OF DIPHTHERIA IN THE PARISH OF "PAIN COURT."\*

BY GEORGE T. MCKEOUGH, M. B., M. R. C. S. E.,  
CHATHAM, ONTARIO.

The parish of Pain Court, which is inhabited by about 250 families—exclusively French Canadians—adjoins the Dover Plains in the County of Kent, notorious for their malaria and ague. The land is low and flat, the soil a rich clay, and the district an agricultural one. The great majority of the people reside along the banks of a winding creek which runs from one end to the other, and is the principal source of drainage for the parish. In the spring months this creek is a flowing stream, and carries off the refuse material of the entire locality, the larger part of the remainder of the year it is either dry or contains stagnant pools of water. The sanitary environments of the various habitations are perhaps superior to those found in country districts generally, from a natural cleanliness of habit of the people. There is however, no system of drainage whatever. About the centre of the community is a church, school house, saw mill etc., the usual conglomeration of a small country village. Malarious affections are exceedingly common; typhoid fever as yet exceptionally rare; scarlatina and diphtheria have occurred sporadically, but there had been no cases of either for a year or more until the late violent outbreak of diphtheria of which the following is a brief report:

The first cases which occurred were two children of J. B.'s aged respectively 5 and 11 years. They both presented symptoms of the disease the same

day, Sept. 16th, and within a few hours of one another. During the following week four more children aged 6, 8, 9 and 14 years, of the same family contracted the disease. They all recovered save one—the youngest, aged 5 years, who died Oct. 3rd, being ill 18 days. The cause of death was asthenia. Several members of this family had diphtheria about two years before, when one died; and a year previous to this many of them had scarlatina. This man's house is situated at the very outskirts of the parish of Pain Court, and is surrounded mainly by English speaking people. The house is an old frame building, located upon a slight rise of ground. The barn yard is distant at least one hundred yards up stream from his house. There was nothing special about the premises to indicate any source of generated specific poison except the aforesaid creek, which runs through the corner of his lot, not twenty yards from his house, and which drains his barnyard. The bed of the creek just here is deeper than ordinary—in consequence, there has been a stagnant pool of water all summer, which imparted characteristic odors to the neighborhood especially at night.

2. The next family afflicted was almost at the other extreme end of the parish, about five miles distant. A boy of P. L.'s, aged 6, was seen by Dr. Holmes, Oct. 9th, and laryngo-tracheal diphtheria diagnosed. This child had been unwell for two months previous, was anemic, slightly jaundiced, and had frequent attacks of epistaxis. For two weeks prior to the onset of the croup the child had a very sore throat, for which he was kept within doors. Inspection of the throat on several occasions by the parents revealed redness and some swelling of the fauces, but no white patches. During the afternoon of Oct. 7th his throat affection having improved he was permitted out for an hour or more; the greater part of the time he played about the barn-yard or creek. The child made no complaints on going to bed, but his father on awaking the following morning heard him breathing "croupy." The child died Oct. 10th. A brother and sister of the above aged 10 and 12 contracted diphtheria, the former Oct. 29th, the latter Nov. 3rd. Both recovered. The creek passes directly in front of this residence, not thirty yards away. Its bed is here also deeper than usual in its course, and the rainfall

\*Read at the Chatham Med. and Surg. Society. January 8th, 1886.

during the recent months being heavy, water has remained here for some time past stagnating. There are several large elm trees intervening between the house and creek, which have a tendency towards keeping the house damp, notwithstanding an elevated foundation. The barn yard is quite thirty yards above the house located close to the creek. The direct surroundings of the house from a sanitary point of view were good. All the members of the family have frequent attacks of malarious fevers. Mr. L. recently had a most violent and obstinate attack of diarrhœa. Some time ago, a young lady residing here had a severe attack of hæmatemesis. The most careful inquiry failed to elicit any evidence of communication between these two families. There had been no cases of diphtheria in the parish or in the township for a year or more. As a people the inhabitants of the parish live almost exclusively to themselves having very little communication with the outside world.

The French people are particularly sympathetic, and during illness or death, they throng the afflicted house, condoling and lamenting with the bereaved ones. The case of Mr. L.'s proved no exception, notwithstanding repeated warnings. During the illness and after the death of his child the neighbors were assiduous in their attendance at the sick room. The result was most disastrous; within the next few weeks the following cases occurred all within an area of half a mile, which I will hereafter term the "infected area" as a means of designating it.

3. M. B.'s child aged 2 years, exhibited symptoms of croup Oct. 21st. The child had been feverish and unwell for a few days previous. Died Oct. 24th. Four other children aged 3, 5, 7 and 9 years in the same house had sore throats with white patches, fever and some glandular enlargements in the neck. They all recovered.

4. F. P.'s children aged 2 and 5, one died Oct. 24th, and the other Oct. 30th from croup. They were each ill about 7 days, becoming "croupy" a few days before death ensued.

5. L. B.'s child, aged 11 months, sickened Oct. 24th and died Oct. 31st from croup. Four other children of the same family aged 2, 4, 6 and 8 had sore throats, two were quite ill, but all recovered.

6. T. B. lost two children—one aged 3 years died Nov. 7th, was ill for two weeks with a sore

throat, foul breath and fever. The child was apparently almost well when it became "croupy" and died two days subsequently. The second aged 13 months, died Nov. 14th—was ill 4 days. Breathing was strident from the beginning of its sickness. Two other children of the same family aged 5 and 7 were quite ill with fever and sore throat, and coughed up "large pieces of black and white matter," but both recovered.

7. E. C. lost a child aged 4, which sickened Oct. 18th and died Oct. 21st of laryngeal diphtheria.

8. H. D.'s child aged 1 year was taken ill Oct. 20th, was seen by me the same day. Fauces were covered with a thin coating of greyish membrane. Temperature 102° F.; pulse 140—recovered.

9. M. C.'s child aged 2, sickened Nov. 6th and died Nov. 8th of croup. Two other children of the same family aged 3 and 5 were also ill about the same time with fever and sore throat, but both recovered.

10. M. B. had three children sicken the first week in November with fever and sore throat. White patches were distinctly seen in their throats by their parents.

11. N. B.'s child aged 20 months, taken ill Nov. 10th with fever and sore throat, developed symptoms of croup on the 15th and died on the 17th.

All these cases occurred in the infected area. Communication between all these different families was constant.

12. C. B. aged 21, mother of the last child (No. 11) was taken ill Nov. 17th. I saw her Nov. 27th, pulse 140 R. 30, temp. 102.5°. Fauces covered with a thin greyish membrane—recovered.

During the first part of her illness this patient was removed from the 'infected area' to the house of a friend 4 miles distant in the adjoining parish with the following result:

13. J. R.'s only child aged 2 years and 8 months contracted diphtheria two days after the last patient was brought to his house. The child died suddenly while sitting at a table eating Nov. 29th.

14. C. D.'s child aged 4 years sickened Nov. 30th and died Dec. 10th of croup. This man is the father of Mrs. C. B. (case No. 12), and throughout her illness was going to and from his own house, eight miles distant situated on the river Thames, a new house with every facility for good drainage and very good sanitary surround-

ings. No other cases occurred in his own family or in that of his neighbors.

15. J. O.'s children, four in number, aged  $4\frac{1}{2}$ , 7, 9 and 11 were all taken ill the latter part of November—the youngest died of laryngeal diphtheria, the others recovered. This man lives about a mile from the 'infected area,' but in the same parish. The first child that contracted the disease in this family was present during the illness of a child (case No. 3) in the infected area. The neighborhood here is very sparsely settled and no other cases occurred near by.

16. J. B. lives several miles from Pain Court in the parish of Big Point; attended the funeral of P. L.'s (case No. 2) child. Shortly after, three of his children aged 2, 5 and 7 were attacked with diphtheria, the youngest died Nov. 2nd of croup, the others recovered.

The three following cases occurred in the village in the centre of the community. I could obtain no evidence of direct or indirect contact with the 'infected area' or other source of contagion. It is however very probable that some member of the families attacked were present at some of the funerals of the infected bodies.

17. J. B.'s child aged 18 months—sickened Oct. 17 and died Oct. 24th of croup.

18. J. L.'s child aged 20 months sickened Nov. 4th and died Nov. 14th of croup.

19. J. B.'s child aged 3 years sickened Dec. 13th and died Dec. 15th of the same.

Commentary.—*Origin of the outbreak.*

There are yet many obscure and moot points to be elucidated before the etiological problem of *diphtheria* is finally solved. Of late years the opinion has been, I believe justly growing, that there is some intimate relation between damp and other insanitary factors, and the virus of this disease, yet only recently an English authority Dr. Meymouth Tidy, in a report upon an epidemic of *diphtheria* stated that "it is a doubtful question whether *diphtheria* ever arises from such a cause as defective drainage." Is there any reason to suppose that this outbreak accords with the theory of a special development of infection. The fact that certain isolated cases have occurred in the district at various times points either to the existence of some unhygienic influence capable under certain conditions of generating the specific contagium of *diphtheria*, or to a quiescent state of the

poison introduced at some past epoch and having its vitality renewed on certain occasions from causes yet unknown. In the first family in which the disease occurred, that of J. B., there are two possible factors in the causation.

1st. The presence of the stagnant creek, with its decomposing vegetable matters, etc.

2nd. The fact that two years previously *diphtheria* ravaged this family, there being no subsequent disinfection of the premises; the poison remaining dormant from then until the present, and now again becoming active. Morrell McKenzie mentions a case in which the poison remained latent for three years and then produced its characteristic effects. The strictest inquiry could not elicit the remotest evidence of any source of contagion.

As regards the second family in which the disease appeared, that of P. L. which occurred a week after the death of J. B.'s child, there were also several factors, each one of which may possibly have been the exciting cause of the disease. No communication of any kind took place between these two families. Diphtheria had never before invaded this house or the immediate neighborhood, and the house was a comparatively new one with a good foundation. There was however, as in the first case the presence of the sluggish polluted pool of water, besides here were the large elm trees, already referred to, which were a constant source of dampness, especially during the past summer, as the rainfall has been comparatively heavy. The previous health of the child may have been an element in the development of the attack. Many authorities believe in the progressive nature of *diphtheria* under certain conditions from a simple catarrh of the throat.

"Drs. Wood and Formand considered that the inflammatory process of an acute pharyngitis may be a sufficient stimulus to develop the common micrococcus of the mouth into a state in which it becomes capable of producing all the characteristic phenomena of *diphtheria*." Again, it is just possible that the germs of the disease of the cases which occurred two years ago may have been carried down the creek and lodged in the stagnant pool remaining there inactive until the present, when their potency has been revived.

*Diffusion of the disease.*—Whatever may have been the immediate origin of the outbreak, it is

unquestionable that its dissemination was owing to its contagious nature, contact with, or close proximity to one affected with the disease was the principal mode of communication. There were instances, however, in which the poison was conveyed several miles to children by a parent not ill with the disease.

It might be asked why the disease should spread with such terrible virulency from case No. 11 in the series; whilst in the first family the infection apparently exhausted itself at its starting point. It will be remembered that the first premises attacked are situated on the very verge of the parish and the surrounding neighbors, mainly English speaking people, were thoroughly imbued with ideas of the infectious nature of *diphtheria*, which ideas were imparted to their more immediate French neighbors, and as a consequence when it became known that diphtheria was in their midst the infected house was shunned. On the other hand the population in the "infected area" were entirely French, and notwithstanding repeated warnings and palpable evidence would not believe that the disease was contagious.

*Relationship between diphtheria and the so-called true croup.*—The evidence obtained from this epidemic leaves little room to doubt from a clinical view of the facts that the fellowship between diphtheria and what was long known as membranous or true croup is an indissoluble one. If a child is ill with a disease characterized by a membrane situated in the larynx and trachea and another child comes in contact with the sick child and almost immediately contracts a disease characterized by a membrane situated on the tonsils, soft palate etc, or *vice versa*, the membrane in each case being almost identical in its macroscopical and microscopical characters, and these phenomena occur and recur in the same epidemic, the conclusion is inevitable.

*Other Features of the Epidemic.*—The most marked characteristic of the outbreak was the pronounced preference the local phenomena of the disease had for the larynx and trachea. Out of 47 cases there were 16 deaths from "croup." In other respects the type of the disease was not malignant, but it illustrated in a striking manner that the mildest case may assume that form of the disease in which medical skill is almost useless. The character of the membrane was thin, pearly

grey in color; there was but little hyperæmia or œdema of the throat, scarcely any glandular enlargements, and septic symptoms were but little marked. An analysis of the deaths in reference to age bears out previous statistics. Between the ages of 1 and 5 years, 22 had the disease and 17 died; between 5 and 10 years, 21 had the disease and but one died; between 10 and 15 years, three had the disease and all recovered; one adult only was attacked and recovered. Another peculiarity of the outbreak was the deplorable fact that only 7 of the 47 cases received medical assistance. Two were seen by physicians after croup was fully developed, jaborandi was given in one *per ora*, and its alkaloid hypodermically in the other, the characteristic effects of the drug were obtained, but both children died. The adult case was seen on the 10th day of the disease in a critical condition, temperature 100.5°, pulse 140, resp. 30; membrane visible in the throat. Boro-glyceride applied locally. Milk, whiskey and tr. ferri mur. were administered liberally, and the patient recovered. Another case, a child aged 11 was seen a few hours after feverish symptoms were first observed, the characteristic exudation was present in the throat. Tr. ferri mur. was given in 1 m. doses every half hour for a time, afterwards every hour; quinine was also administered, and the child was well in a few days. Several children died from croup within a stone's throw of this house during this child's illness. Had the treatment the effect of limiting the membrane to the pharynx? The other three cases which received treatment presented no unusual features.

#### SUPRAPUBIC URINATION.\*

BY J. P. RUTHERFORD, M.D., CHATHAM, ONT.

Suprapubic urination, the subject which I propose summarily to deal with in the present paper, may arise from three distinct causes. 1st. Congenital deficiency of the anterior wall of the bladder, exstrophy. 2nd. From an opening caused from malignant disease, or traumatic injury. 3rd. Superinduced by the hand of the surgeon in the operation of tapping. To the last of these my thoughts will be mainly directed, not so much to

\* Read before the Canadian Medical Association, Chatham, September 2, 1885.



show any original plan, as to compare different methods, for the purpose of bringing out a full discussion of the question.

The necessity for any such operation—I mean “bladder tapping”—in any region, simply hinges on two fundamental conditions. 1st. Complete retention. 2nd. The exhaustion of all simpler expedients for the relief of this condition. And here is where the wedge of controversy enters. Although its necessity is admitted by all surgeons in some extreme cases, eminent men differ as to the place of tapping, and just when it shall replace other methods of relieving an over-distended bladder. Dr. Coulson extends the above rule for guidance by advising the operation of anterior tapping in all cases of “engorgement” produced by enlargement of the prostate gland, necessitating the frequent and difficult introduction of the catheter to remove residual urine, thus giving the irritable bladder and prostate perfect quietude.

The main causes of complete retention are, spasmodic and organic stricture of the urethra, occlusion of the same by impacted calculus, traumatic injury, enlarged prostate gland, or malignant disease. The two latter supply nearly all the cases demanding the operation in question. To relieve a patient in such distress, after thoroughly manipulating with catheters of different sizes and kinds, combined with such adjuncts as opium, chloroform, hot baths, etc., the honest and anxious surgeon, in the face of failure, will ask the question, “What next?” In answer, if we can introduce a filiform bougie, perform Symes’ operation called “external division”; if not, we have “external urethrotomy” at our command, called perineal section by some, cutting without a guide.

Again, we have forcing the stricture with a silver catheter, now obsolete; and many other methods only deserving a passing notice, such as cutting out the stricture, Dupuytren’s vital dilatation, Wakley’s sliding tubes, Arnold’s fluid pressure, internal use of caustics, electrolysis, etc. Then, again, we can tap the urethra directly behind the stricture, if sacculated or distended with urine—this method was strongly advocated by Profs. Liston and Guthrie—a difficult operation, save in the condition of urethra as above, and one at present very seldom resorted to. Any successful operation on the urethral tract, when at all practicable, is the best, as the result is more likely

to be permanent; and to save time, it is sometimes advisable to give temporary relief to the patient by immediate aspiration. All the foregoing methods of relief having failed or proved unsuitable to the case, and we wish to establish a new outlet for some days—nay, it may be some months, or even years—what shall and must be done? Tap the bladder, and do it anteriorly above the pubis. I advocate this outlet as being on the list next to the natural way. Four different methods have been advocated, differing, not so much from their methods of performance as their points of entrance. Two of these have fallen into disuse—the one called “subpubic,” first and last performed by Voilemier; the other, called “pubic,” first performed by Dr. Brander, of Jersey, in 1825. These methods I will not attempt to describe. The most favored positions to-day, are, through the rectum, hereafter called the “posterior method,” and suprapubic, called “anterior method.” The posterior is also called the English method, and was advocated and practised by Mr. Cock, of Guy’s Hospital. The anterior or Irish method, strongly upheld by Fleming, was first performed by Dr. Wiery in 1701 and pronounced the best by Sir H. Thompson, Keys, and many other eminent surgeons, in all cases where a permanent opening is required for any length of time.

*Operation.*—An assistant, long-curved trocar and canula, soft catheter, some tape, adhesive plaster, and chloroform are required. The catheter should be No. 6, and exactly fit the canula, in order to allow of the escape of any mucus, muco-pus, blood or epithelial debris present. After administering an anæsthetic remove the hair from the mons veneris, place the patient in a semi-reclining position, enter the trocar and canula through the integument one inch above the pubis, in the median line, directing its course slightly downwards. During the operation the bladder is supported antero-laterally by the assistant. The tissues down to the bladder should be pierced by the trocar and not incised. This method was first adopted by Mercier, and is, I think, a most excellent modification of the former plan, as it fortifies very much against extravasation of urine, the canula being better, more firmly and securely held *in situ* by the muscular contraction of the bladder wall at the one end, and of the skin at the other. The trocar must be very sharp-pointed: if not, the

bladder may be separated from its areolar bed before piercing. This accident would invite trouble by way of abscess from extravasation of urine. It must be replaced by the soft catheter before the bladder is emptied. The objects of the soft catheter are four-fold :

1st. To save coats of the bladder from rough edge of canula.

2nd. To allow more fully of washing out of the same.

3rd. By attaching a rubber tube, to conduct the urine to a suitable receiver.

4th. By keeping it introduced well into the cavity, it prevents the urine from escaping around the canula, and holds the latter better in position. If faintness supervene, discontinue the flow of urine and administer a stimulant. Ether hypodermically answers admirably.

CASE I.—J. S.—One of malignant disease, involving prostate and neck of bladder, necessitating for some time the use of the catheter, finally ending in complete occlusion of the urethra, and baffling relief from the latter. Retention, extravasation and certain death on the one hand, or tapping the bladder, on the other, stared the patient and friends in the face. After consulting with patient and friends, an operation (the only hope of prolonging life) was decided on, and finding no possibility of entering per rectum from the extension of the disease in that direction, the anterior method was chosen. The operation was performed as herein detailed, and his lease of life was extended fully two weeks. At his death, urine passed freely through the new urethral outlet, and although it is customary, after consolidation of the tissues about the canula (say four or five days), to remove both canula and catheter, in this case, from extreme debility of the patient and atony of the bladder, the catheter was left in.

CASE II.—W. C.—Was one operated on for false passage made by patient himself in attempting to procure relief and save a fee. The catheter when in this passage, could be felt some two inches up between bladder and rectum, and could not be directed in any more favorable locality for getting urine, and relieving patient. Different sizes were tried, but profuse hæmorrhage opposed a prolonged persistence in these manipulations. The only choice here lay between repeated aspirations, perineal section, and tapping. This was given in

favor of tapping and the anterior operation. My reasons for such a course were—1st. I feared the urine would trickle around the canula, and enter the torn region between bladder and rectum, and there set up abscess and possibly worse symptoms. 2nd. Aspiration must have been performed if I had chosen "perineal section," as it occurred just after dark. 3rd. Having thus to enter the bladder with a needle, and not being over-sanguine of getting the urethral opening from the perineum, it was considered better to use a large trocar and canula at once. To illustrate the impunity with which the bladder may be tapped, even with a large instrument, I might cite the case of Dr. Dox, in which the bladder was punctured anteriorly some eight times in succession in as many days, to relieve a case of retention, after which the patient re-acquired the power of making water per *vias naturales*. The above case you will find recorded in the New York *Medical Record* for June, 1872, by Dr. Clark, of Geneva. The operation was performed and a perfect fistula established without any bad symptoms intervening. On the fifteenth day after the operation, a catheter was with difficulty passed into the bladder and tied in. It was taken out and re-introduced twice in four days. The artificial opening completely closed up, and nothing remains to-day but a cicatrix in the hypogastric region. The patient is quite well, and has been making water by the good old way ever since.

CASE III.—This case was one of enlarged prostate gland, coupled with vesical catarrh. The occlusion of the prostatic urethra was complete, as can be testified to by my able *confrère* Dr. Bray, who very kindly assisted me in trying to overcome our patient's wants by catheterization, etc. Failing in our efforts to relieve, we operated April 3rd, 1879, and he lived over four and a-half years, until the fall of 1883, making water during this time more naturally by the new channel than he had for years by the old, as he could retain his water better, and for three or four hours at a time, and even went about and attended to his ordinary duties. The only difficulties experienced by him were excoriation of the integument around the new orifice from contact of urine and branch fistulous tracts running from main channels. The former was always readily relieved by a closer attention to cleanliness, combined with the use of oakum and carbolized sponges over the excoriated

parts; the latter by introducing and keeping in a catheter for a short time, which could be done the very day he died, showing that the urethra was almost perfect, and that he passed over to the majority in the end from general decay and old age (having turned seventy-eight years), and not from any difficulty in urinating. Not one drop of urine, mucus, pus or blood ever escaped from the passage, and all attempts to catheterize the same proved futile. This only goes to prove the perfect occlusion of the urethra. I give a summary of reasons why the anterior operation seems to me preferable to the posterior: 1st. According to some of the very best authorities—Sir H. Thompson, Keys, Coulson, etc.—the posterior method should only be used when wanted for a short time. Hence I claim aspiration should be performed instead; and when an opening for any length of time is required, tap, and do it anteriorly.

2nd. As we do not always know how long we may want this substitutionary process, and as the dangers are about equal (or if anything in favor of the anterior method), perform that which you can use long or short, and close at will.

3rd. More easily performed; region more accessible to the surgeon.

4th. The most common cause, enlarged prostate, excludes the posterior.

5th. Dangers greater in posterior; if seminal vesicle should be wounded, epididymitis and abscess may be the result; as to wounding peritoneum, about equally divided; *nil*, with ordinary precautions, in either case; extravasation of urine, abscess and blood-poisoning less in anterior if the soft catheter be used and no incision made.

6th. The function of the rectum is not interfered with.

7th. The retaining power of the bladder is present in the one case and not in the other, as was forcibly illustrated in Case III. The patient could hold his water for three or four hours, much longer than before the operation, and by getting up, completely empty the bladder by making the opening the most dependent point.

### CHEYNE-STOKES RESPIRATION—A NEW THEORY.

BY THOMAS W. POOLE, M.D., LINDSAY, ONT.

This curious condition, having been briefly discussed in the editorial columns of the last LANCET (February, 1886), I would be glad, with permission

of the editor, to add the following contribution towards the elucidation of this difficult problem.

All the theories put forward on this subject are based on the assumption that impure venous blood, loaded with carbonic acid and deficient in oxygen, acts as a stimulus to the nervous centres. I am aware that this view of the case—the stimulating character of impure blood—was suggested by a high physiological authority, I believe by Dr. Brown-Sequard himself. But it must be remembered that this has merely been put forward as a possible explanation of certain phenomena not otherwise accounted for, and that it rests upon no actual facts of inductive science.

Is it not absurd, on the face of it, to attribute to bad blood, deficient in oxygen, the power of *stimulating* the nerve centres, in the face of the admitted physiological law, that the activity of those centres is directly dependent upon their receiving a due supply of oxygenated blood? Is it not an outrage on physiological propriety to speak of utilizing "blood loaded with impurities with which to stir up the sluggish nerve centre"? Surely there is something wrong about a theory, or an explanation, which not only common sense would seem to negative, but which is directly antagonistic to established physiological facts.

In the explanation of this curious state, which I here venture to offer, venous blood, loaded with carbonic acid and deficient in oxygen, is held to play its legitimate part of a depressant and paralyzer to nerve function. In order that this shall appear, certain other modifications of current physiological teaching must be made. Nevertheless, in doing this, I shall ask the reader to follow me only so far as I am able to adduce for these modifications the very highest physiological authority.

Why was impure venous blood assumed to be a stimulus to nerve function? Because it was found that "a deficient supply of oxygen in the blood produces a contraction of the arterioles of the body," and this arterial contraction was held, and is still held, to be due to a *stimulus* from the associated nerves,—the vaso-motor nerves, of the arteries. This stimulus, it was taken for granted, came from the venous blood.

Is this doctrine true,—that arterial contraction is due to nervous stimulation? I will ask the reader to satisfy himself of the correctness of the proof to the contrary, to which I am about to refer

him in the briefest terms. The arterial muscle belongs to the non-striated or involuntary class of muscles; and there is ample physiological evidence that *this class of muscle contracts, not when stimulated by its motor nerves, but when these nerves are cut, or paralyzed, or dead.*

Here are the facts, which also show that the arterial muscle is not alone, or exceptional, in the rôle just attributed to it.

The muscles which close the glottis and those which open the glottis are both under the motor control of the inferior laryngeal nerve. When this nerve is cut, or paralyzed, as by pressure of a tumor, etc., the glottis closes spasmodically, *both sets of muscles contracting*, and the closure takes place, as Dr. Burdon Sanderson says, "not because the dilating muscles do not act," "but because they are overpowered" by their antagonists. (Handbook for Phys., Laborat. Amer. ed., pp. 308, 317, 319; Dr. Austin Flint, Prac. Med., 5th ed., pp. 294, 309, 371; Guttman, Phy. Diag, p. 40). Spasm of the glottis is therefore due, not to nerve stimulation or "irritation," but to nerve paralysis.

The horse breathes exclusively through his nose, and this cavity is closed by the *contraction* of its constrictor muscles when the facial nerve is divided. As a consequence the horse dies from asphyxia. (Strangeway's Vet. Surg., p. 209).

All our text books assert that section of the vagi produces paralysis of the œsophagus. This is manifestly an erroneous conclusion. If it were true, the œsophagus would be reduced to a mere flaccid tube. Instead of this, Dr. Dalton states that the food and drink swallowed, "in a few minutes are suddenly rejected by a peculiar kind of regurgitation." (Phys., p. 473). Dr. Burdon Sanderson has it among the effects of the section referred to, that "the muscular fibres of the stomach are paralyzed, so that regurgitation of food from the stomach is apt to take place. (Handbook, etc., p. 318). This behaviour of the gastric muscle, and of the œsophageal muscle is a proof, not of paralysis, but of more or less active contraction. If the candid reader agrees with me in this, as I think he must, I will ask him to ponder a moment, on the singular mistake which has been made in interpreting the results of this experiment. Could it be possible that a physiologist could claim for an experiment a result in accordance with the theory uppermost in his mind, in

opposition to the visual facts before him, and that others would go on blindly echoing his dictum? Something like this may appear again, as we proceed.

If the reader choose to follow up the enquiry, he will find that the bronchial, intestinal, and other involuntary muscles follow the same law.

Among other effects of section of the cervical sympathetic, as recorded by Dr. Brown-Sequard, are: contraction of the erectile muscles of the ears, contraction of the iris,—of the eyelids,—of "almost all the muscles of the eye,"—of "the muscles of the angle of the mouth," and of others. Among all these evidences of muscular *contraction*, can it be possible that the effect of this section on the *arterial muscle* was one of dilatation? It has been so assumed, and is so stated. But not by Dr. Brown-Sequard. In his "Lectures on the Central Nervous System," in which the effects of this section are detailed at great length, *Dr. Brown-Sequard nowhere speaks of the arteries as relaxed or dilated.* With him, it is always "the blood-vessels" which are "paralyzed," and "the blood-vessels" which are "dilated." He says, "the hanging down of an animal by holding it up by the hind legs in producing a congestion of the head, produces very nearly all the effects of this section." (pp. 140-143). All this, and other facts which might be urged, did space permit, is quite consistent with a condition of mere venous fullness, resulting from arterial contraction.

That this is, of necessity, the actual condition present, is not a mere conjecture, but admits of positive physiological proof, if the law of uniformity of cause and effect counts for anything in physiology.

Dr. Burdon Sanderson shews that the splanchnics are the great vaso-motor nerves of the abdominal viscera, and he states that after their section, "the vessels of all the abdominal viscera are seen to be dilated." What "vessels" are these? The reader has been told by this eminent physiologist that after section of vaso-motor nerves the corresponding arteries are "paralyzed" and "dilated," and he naturally expects to find this shewn to be the case after section of the splanchnics. Dr. Burdon Sanderson does not here once allude to the state of the arteries! What he finds is that "the portal system is full of blood." "A quantity of blood, is, so to speak, transferred into the portal

system, and thereby as completely discharged from the systemic circulation as if a great internal hemorrhage had taken place." (Handbook p. 260). In other words, the arteries are empty and the veins are full. Just think of it! On the theory of the text books, the arterioles here *ought* to be "paralyzed and dilated." They are empty and contracted.

Let me remind the reader that the law of uniformity of cause and effect, demands that what is true of the relative state of the arteries and veins, after section of the splanchnics must be true also, after section of the cervical sympathetic, and since the arteries are thus shown on high physiological authority to be empty, and the veins full in the former case, the same condition must be held to prevail also in the latter.

The arterioles are always empty and their muscles contracted when their nerves are cut or paralyzed, and such is also invariably their condition *in death*, when nerve force is extinct.

This is true even after the operation of "pithing," in which the medulla and spinal cord are destroyed, as anyone can satisfy himself, as I have done, by actual experiment. This is inadvertently proved to be the case by Dr. Burdon Sanderson, in his experiment designed to prove the contrary, as the reader will see by carefully studying the details he gives, in which it is shown, that of two frogs experimented on, the heart in both being exposed and the ventricle cut open, the one whose nerve centres were uninjured bled most from the aorta. "In the frog deprived of its central nervous system only a few drops of blood escape,—the quantity that is to say previously contained in the heart, and in the beginning of the arterial system. In the other, the bleeding is not only more abundant but continues for several minutes after the section." (Handbook, etc 296).

The reader who candidly studies this experiment, as given in the Handbook, pp. 246, 296, cannot fail to see that it is the arteries of the unpithed frog which contain most blood, and that it is the arteries of the pithed frog which are empty, and that here "the whole mass of blood has come to rest out of reach of the influence of the heart," (p. 246)—that is the nervous system: an effect brought about by contraction of the arterial muscles, which "in dying drive their contents into the veins." (Kuss. Phys. p. 181).

This is their condition in asphyxia also, in which case the great veins if cut into will spirt like arteries (Handbook p. 332), and this is what occurs as part of the phenomena of the Cheyne-Stokes respiration, to which we now come after this long but unavoidable prelude.

Let the reader bear in mind that bad blood, arterial contraction, and venous engorgement go together, and that so far from this being a state of nervous "stimulation," it is precisely what occurs in the dying, and finds its completion in death!

#### A NEW THEORY SUGGESTED.

The salient points of the Cheyne-Stokes respiration are, "alternating periods of arrest and of excitement of respiration." The periods of suspension of respiration "usually last from a quarter of a minute to half a minute, while the periods of rise and fall of respiration are about the same or rather longer duration." "In the former period, the thorax is absolutely motionless and the patient appears almost as if dead. Then a faint wave of inspiration is noticed, followed by other respiratory efforts shallow and slow. The succeeding respirations become gradually deeper and quicker, until the chest is agitated with severe dyspnoea; then, arrived at its maximum the paroxysm abates, the retrocession being as gradual as the onset, and at the end there is a period during which the breathing is in complete arrest." That at this stage "the arteries are strongly contracted," is proved not only by the increased tension of these tubes, but by the arrest of the process at the outset by the inhalation of nitrite of amyl, which dilates these vessels. (Sanson Phys. Diag. Dis. of Heart pp. 35-37).

Let us assume with Dr. Sanson and others, that there is here a condition of partial paralysis of the respiratory centre; that the blood is imperfectly arterialized, is loaded with carbonic acid and deficient in oxygen. Such a condition of things will naturally produce, not stimulation, but failure of function in the nervous centres. We have seen above, that nerve failure means contraction of the arterioles, systemic emptiness and venous engorgement. This condition gradually takes place, the great mass of the blood being transferred to the venous reservoirs "out of reach of the influence of the heart," as in Dr. B. Sanderson's pithed frog.

But as the heart continues to beat, it is fair to assume that a small quantity of blood still finds

its way through the lungs, and from its very scantiness, is capable of being aerated by means of the exchanges of gases still going on in the lungs, owing to the presence of residual air, during the temporary, partial or complete arrest of respiration. (Kuss). As a consequence, the quantity of blood reaching the nerve centres, though small, is at least partly oxygenated, and serves to revive the function of these centres, "imperfectly at first," but with momentary improvement.

The effect of this revival, on the vaso-motor centre, is to facilitate the dilatation of the arterioles, in which the pulmonary vessels share, permitting, ere long, the inrush of venous blood from the distended vena cava and portal system, and its transmission onwards through the heart and lungs.

This corresponds to the period of increase in respiratory function, in which the laborious efforts of a feeble mechanism have been mistaken for an "exaggerated impulse" from excited and overacting or "exploding" nerve centres.

Meanwhile, impure blood from the venous reservoirs, (finding an entrance through the now fairly dilated pulmonary vessels,) begins to fill the lungs in such quantity, (as it is drawn onwards by an inequality of pressure, towards the as yet unfilled arteries) that the whole mass of blood, failing to be arterialized with sufficient rapidity, again becomes unfit for the maintenance of nerve-function and the perpetuation of processes depending upon it.

In such a case, a previously weak organ or centre, is the first to suffer. The medulla oblongata is such an organ in this case, and its contiguous centres for respiration and circulation fail together. Bad blood and deficient blood, acting on centres previously paretic, or enfeebled, have done their work, and again the respiration is suspended. The vaso motor centre is again so functionally weakened that it loses control of the arterial muscle—the "inherent contractile force," which all physiologists assign to muscular tissue, thus freed (as in the examples enumerated above), induces "the strong arterial contraction" referred to by Dr. Sanson, which contraction of the artery is all the stronger the nearer nerve force is to cease in the extinction of life.

This arterial, or systemic contraction, again empties the lungs, and refills the venous reser-

voirs, from which the blood is again drawn, at first slowly and then more rapidly, as the process repeats itself.

Here then, is an explanation of the Cheyne-Stokes' respiration, based upon sound—though as yet unacknowledged—physiological principles, according to which paretic and enfeebled nerve centres are helped by their appropriate pabulum—oxygenated blood—and are overwhelmed and have their function suspended by what is naturally calculated to poison and paralyze them,—impure, venous blood, deficient in oxygen and loaded with carbonic acid. As a proof, if such be needed, that carbonic acid is a poison and not a stimulant, it may be mentioned on the authority of Periera, that the inhalation of this agent produces spasm of the glottis, and this, we have seen above, is undoubtedly due, not to nerve stimulation, but to nerve paralysis.

How such an agent could ever be regarded as playing the part of a stimulant, can only be accounted for on the exigency of an erroneous theory, which demanded its modicum of nerve force from nerve centres actually being paralyzed.

All of which is respectfully submitted to the judgment of the candid reader.

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## Correspondence.

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To the Editor of the CANADA LANCET.

SIR,—Not with an idea of imparting anything striking or probably new even to many of your readers, but rather with the hope of having some further light thrown on the subject, I make mention of the following cases.

In this section of the country I have met with no less than five cases of peritonitis in the past month; in fact there may be said to be an endemic, as I have since learned from a brother practitioner that in their town they had met with nearly a dozen cases in the same length of time. These cases, which were nearly all fatal, presented all the ordinary symptoms of peritonitis, but the peculiarities were three-fold.

1. There was no apparent cause for the trouble, as all the patients, up to the moment of being seized with violent abdominal pains and in most cases vomiting, were apparently in the enjoyment of good health. The seizure was very acute and

in two cases the patients died within forty-eight hours.

2. In all the cases except one—a young woman of eighteen—the victims were young men between twenty-five and thirty. I think all the cases mentioned by my friend were young men.

3. Nearly all had very severe nose bleeding. In fact in one the epistaxis was the direct cause of death. The hemorrhage had lasted almost four hours before I could get to the patient. All the ordinary means for checking the bleeding being useless, I resorted to plugging the nares, anteriorly and posteriorly, but although the patient lived some three days afterwards she never seemed to rally. In this case the peritonitic symptoms abated very markedly after the severe hemorrhage. I thought this might probably be the effect of the bleeding, but if so the remedy was almost, if not quite as bad as the disease.

I have not been able to obtain any post mortems, but the medical friend above mentioned had found perforation of the cæcum in the one case in which he was able to obtain an examination of the patient after death.

The usual mode of treatment by opiates, warm fomentations, etc., seemed almost useless, excepting their effect in quieting pain. The tongue presented a red appearance, very dry and at the tip covered with small elevations resembling minute acne. I will not encroach further on your valuable space, but hoping to hear from some brother medico in regard to this matter,

I am, yours, etc.,

Essex Centre, Ont.

P. A. DEWAR.

## TO THE MEDICAL ELECTORS OF THE SAUGEEN AND BROCK DIVISION.

GENTLEMEN,—

The representation of this riding in the Medical Council having become vacant by the death of our late esteemed member, Dr. Douglas, I beg leave to offer myself as a candidate for the representation of the Division.

As our Medical Council is now one of the established institutions of the country, it is our duty to send those to represent us who desire its continuance and the increase of its powers. I am heartily in accord with the majority of the profession in obtaining those amendments to our Med-

ical Act, which are being applied for at the present Session of Parliament. I also desire the elevation of Professional Status, by all those means which the Act empowers us to attain. One of the most important is the entrance to the study of the profession, viz. :—Matriculation; the degree of B. A. should be required of every student, or at least a course of three years in one of our Universities.

I shall use my best endeavours to obtain such a change in the law as will enable us to punish those practitioners who hire themselves to foreign companies for the purposes of quackery, and shall endeavour by every means in my power to further the interests of the profession at large.

I am, yours, &c., &c.,

GEORGE S. HEROD.

Guelph, Feb. 16th, 1886.

## Selected Articles.

### METHODS OF DIAGNOSIS.

Mr. Lawson Tait, of Birmingham, forwarded a paper to the New York State Medical Society on methods of diagnosis, from which we give the following, (*Med. News*). He maintained that the speculum and the sound, as means of diagnosis, have been productive of uniformly more harm than good. That a blennorrhagic discharge from the vagina of any patient requires the introduction of a speculum, is one of the stock beliefs of the great bulk of general practitioners, but it is certain that nothing of the kind is requisite, and a very large amount of mischief, there can be no doubt, has been produced by this belief. It is not at all an unusual thing for him, on taking part in a consultation with the family physician concerning some such case, to be told by him that he very much regretted that he had not made an examination with the speculum. Others have told him that they made the said examination, and when asked what they saw, or what they did, the answers usually given are that they did nothing, they merely made the examination; that is to say, they passed the instrument and with that proceeding were perfectly satisfied, evidently under the belief that the passage of the speculum was quite as much a curative agent as a method of diagnosis. Similarly with the sound, he had heard many practitioners tell of their experience with the sound, or rather their want of it, and he judged that they looked upon it as a sort of magical charm, the introduction of which into the uterus was to achieve unmeasured good. As a matter of fact,



the sound is one of the most dangerous instruments which ever was invented for the treatment of human suffering, and in his own practice obtains hardly any employment at all.

There is a story which is told against himself by some of his colleagues which he never hesitates to repeat, because it is the kind of accident which is liable to occur to any one, and fortunately the only one of its kind which ever happened to him. It conveyed a lesson of which at the time he stood much in need, and from which warning may be taken with advantage. Many years ago he was asked by the surgeon of a large general hospital to give his opinion on the case of a young woman, who had been in the hospital for some months suffering from a pelvic tumor which seemed to threaten her life. She was hectic, suffering and very ill. The tumor on one side of the pelvis was apparently quite fixed, and he expressed the opinion that it was a collection of matter, but in what position he could not say unless she would allow him to make use of the uterine sound. His surgical friend told him he could do exactly what he thought proper. He had asked for his opinion as a specialist and he would not interfere with any steps he thought fit to take for the purpose of furnishing him with that opinion. Mr. Tait immediately proceeded to use the sound and came, quite erroneously, to the conclusion that the patient was suffering from a parametric abscess. The sound passed, as he thought, into an empty uterus, fixed toward the right side, the uterus being of normal length. Within twenty-four hours the patient miscarried of a fourth-month fetus, and this ended all her sufferings. She speedily recovered and left the hospital cured in a way which nobody expected, and which certainly he did not intend. All such accidents have by no means so happy an ending as this had, and their number is immense. But few months pass without his hearing of a case in which some kind of mischief has been done in this way.

One of the most important methods of diagnosis in abdominal disease, and the first to be considered in examining any case, is inspection. A careful examination, by the eye, of the contour of an abdomen when the patient is lying on her back, with the walls of the abdomen perfectly flaccid, will reveal a good deal to the experienced practitioner. A completely and uniformly distended abdomen may mean that the patient is suffering peritonitis, intestinal obstruction, ascitic effusion, a parovarian tumor, an ovarian tumor, a large myoma of the uterus, or pregnancy. The process of discriminating between these various conditions may very rapidly be completed by one who is accustomed to deal with them. Thus peritonitis may be at once detected or eliminated by the presence or absence of the short and rapid pectoral breathing, which shows that the patient is loath

to use her diaphragm. In fact, by this alone, and without almost any further inquiry, he has satisfied himself as to the nature of the case by a single glance. Ascitic effusion, or on the other hand, is revealed at once by the absence of the pectoral breathing, by the greater flattening of the distention, by its tendency to assume a pyriform shape, the broadest diameter just above the pelvis, by the thickening of the walls due to anasarcaous effusion, and the presence of white lines in the skin of the flanks. If the crest of the ilium sticks out under stretched skin, the diagnosis is again almost complete without further inquiry. If, on the other hand, these subsidiary features are absent, and there be a uniform and complete distention, two conditions widely distinct may be suspected. These are parovarian cyst and hydramnios; and here, again, some very curious mistakes have come under his notice, some of which have had very ghastly results. Parovarian cysts after labor sometimes grow with astonishing rapidity. Hydramnios always occurs with twin pregnancies, and generally in unmarried women, who are of course, disposed to conceal their condition, and mere inspection cannot be depended upon to discriminate these cases.

But inspection will help us very largely to detect pregnancy and myoma, for in these cases the distention is always greatest either at the middle of the tumor or at its upper part, differing in this way completely from ascitic distention; and here one of the most important agents in the diagnosis of abdominal diseases, palpation, comes at once to our assistance, and to the skilled fingers it ought not to take more than a few seconds to discriminate between any or all of these conditions. The percussion note, which is uniform in a case of peritonitis, will easily determine the condition which is present. One or two delicate touches of the fingers of one hand whilst the fingers of the other lie with the most gentle lightness on the other side of the abdomen, will determine the presence of fluid, and it is in this method of palpation that the skill of the practitioner at once becomes visible. The inexperienced hands press firmly upon the walls and may be seen to move to and fro in an aimless fashion as though they were rocking a cradle. The gentlest and tenderest touch alone will reveal what is required. Measurements of the different diameters of the abdomen will teach in a few seconds the leading features which are present: first, that there is fluid; secondly, that it is, or is not, near the surface, being contained, or not, within a thin-walled cyst; thirdly, that there is one cavity, or not; fourthly, the probable character which it presents. The wave excited by gentle tapping is retarded or urged on by the more or less gelatinous nature of the fluid. All these conclusions are indicated with the utmost rapidity to the skilled fingers, and it is absolutely impossible

to teach how this can be, save by the constant practice of the pupil. The parovarian cyst may be diagnosticated entirely from one condition, that is, hydramnios, partly by its thin walls and partly by the fact to which he has alluded, that hydramnios is very easily detected. Ascitic fluid is revealed in the same way, and by the additional fact that here and there we get tympanitic percussion notes.

The large uterine myoma is defined by its firm sense of resistance and its uniform feel and pseudo-fluctuation, also by the fact that it has a smaller diameter at the base than at the middle or upper part. Pregnancy, the rock ahead to inexperienced practitioners, can be infallibly revealed by palpation. First of all, there is fluctuation due to the liquor amnii, and it can be easily detected, and this declares the cystic nature of the mass. If the hand be made to lie gently on the parietes for a few minutes a rhythmical contraction of the uterus, by which at one time it is hard as a cricket ball and at another soft as a cushion, will become perfectly apparent, and this is as infinitely more certain sign than the sound of the fetal heart or placental bruit. The fetal heart is a sound which may guide and sustain the practitioner in his conclusions, but it is so easily imitated by intestinal noises, and often so difficult to find, that it is not to be depended upon with certainty. The placental soufflé is probably more easily recognized than the fetal sounds, but placental sounds are very often, in rapidly growing tumors of the uterus, so completely imitated that there is always a certain amount of doubt connected with them. But the relaxation and contraction of the uterus in pregnancy are points in diagnosis which when once made apparent, can never be mistaken for anything else.

### THE USES OF DIGITALIS.

Dr. W. Symington Brown of Stoneham, Mass., (*Louisville Med. News*), gives the following regarding the use of digitalis:

Digitalis has two marked properties: it is a heart tonic and diuretic. It seems to exercise more control over the circulatory than the nervous system. Next to the preparations of opium and cinchona, I have given it to patients more frequently than any medicine, and the result of my observations for twenty-five years is that digitalis acts slowly, too much so to conclude that it directly affects the nervous system. Another conclusion I have arrived at is, that it is not a cumulative medicine, in the ordinary sense of that term. Our own Dr. Odlin holds the same opinion. On account of its slow solubility in the blood, it may appear to accumulate when too rapidly administered. An interval of six or eight hours should be allowed between doses. In some patients it produced diarrhoea.

In medicinal doses, digitalis steadies the heart's action, lessens the number of beats, allows the coronary arteries to supply nourishment to the enfeebled organ (which is only possible during the diastole), and contracts the arterioles all over the body. In poisonous doses, it seems to tetanize the heart, at last totally arresting its movements. Experiments on the lower animals and a few post-mortem examinations in man show that the left ventricle is always empty and rigidly contracted after death caused by poisonous quantities.

The following is a list of the more important diseases in which digitalis has been given advantageously:

1. In mitral obstruction, and generally whenever effusion occurs from debility. When dropsy supervenes from heart disease, when the face is dusky, the jugular veins distended, the breathing hurried, and the pulse feeble and intermittent—small doses of digitalis, aided by position and stimulants, will often work wonders. In some cases, where the left ventricle is both dilated and hypertrophied, it may be given tentatively.

2. After rheumatic fever, when the pulse is feeble, rapid and irregular, combined with salicylate of soda. It is also useful in the later stages of typhoid fever. In moderate doses it reduces the temperature in all fevers.

3. In atonic uterine hemorrhage, and as a hemostatic after surgical operations on the uterus, it may be alternated with ergot. In giving digitalis it not unfrequently occurs that the pulse is accelerated at first for a few hours, although the final effect is to reduce the number of pulsations.

4. In delirium tremens. Very large doses have been given successfully in this affection. I recollect attending a case in Scotland, many years ago, assisted by my tutor, where we gave tincture of digitalis in half ounce doses, after a fair and futile trial of opium, and the patient recovered. He was a regular toper, full of morbid fancies, and he would only consent to swallow the medicine on condition that I scratched his back, during which interesting process he fell asleep. I remember that Dr. Glen was in doubt whether it was the digitalis or the scratching that saved him.

5. Drs. Nelligan and Corrigan, of Dublin, strongly recommended it in epilepsy. They gave two ounces of the infusion at bedtime, continued for four nights, with an interval of two nights, then repeated as before. My experience of its use in this affection is not extensive, and not very favorable.

6. In spermatorrhœa it occasionally proves beneficial. The influence of digitalis on sexual desire, in both sexes, is decidedly sedative and anaphrodisiac. It only exerts this influence, however, after the lapse of weeks.

7. In bleeding piles. A good form for this disease is the powder made into pills with tar.

each pill containing one grain of digitalis. Four may be swallowed daily.

8. In maniacal cerebral excitement the hot infusion, sweetened, in teaspoonful doses, twice a day or oftener, sometimes answers the purpose of quieting the patient better than the bromides.

To return to digitalis. In all cases great care must be taken to watch the effect of the medicine. It is better to begin with small doses, observing the results from day to day. When we have reason to suspect fatty degeneration of the heart, it should not be given. In ossification of the aortic valves and in croupous pneumonia, digitalis is likely to do more harm than good. As a general rule, it is not serviceable in robust patients; and it only acts as a diuretic during the presence of dropsical fluid. The dose should be diminished as soon as the amount of urine secreted becomes less. The main benefit derived from digitalis seems to be the relief of *irregular* pulsation by imparting tone to the heart and arteries. Like opium, its first effect is stimulating, its second effect is sedative.

#### NOTES ON THE TREATMENT OF DIPHTHERIA BY PROF. DA COSTA.

Diphtheria may continue in an individual for a long time, relapses occurring from self-infection. Treatment must be preventive and individual. In the first place, the strictest isolation must be enforced: remove all unnecessary furniture, clothing and the like from the room; disinfect the sputa, linen and everything from the patient, and, if possible, remove the paper from the walls and wash with some disinfectant. Do not allow members of the family to come in contact with well children, for fear the former may convey the poison to the latter.

The individual treatment is both general and local. In the former, *alimentation* and *stimulation* are of the greatest importance, given, as in typhoid, every two or three hours, day and night. Alcohol is given to the point of tolerance. Begin with  $\frac{3}{4}$  ss to  $\frac{5}{8}$  j of brandy every hour; increase till heart and pulse are improved. The amount a patient suffering with diphtheria can take is incredible; a child, *æt.* 2 years, has been given a tablespoonful of brandy every hour, and  $\frac{5}{8}$  j is quite common. There is present a condition comparable to that found in snake poisoning. Begin the stimulus early.

As to *medicines*, one of the earliest and best treatments is by potassium chlorate,  $\frac{5}{8}$  j to  $\frac{3}{4}$  ss per diem, in divided doses, well diluted. Next to this, either alone or combined with it, is tinctura ferri chloridi, gtt. x every hour or two, for a child *æt.* 10 years.

The rising treatment now is with calomel. It consists in giving large doses frequently, not mind-

ing the free movements from the bowels. Give one grain every hour till twelve doses have been taken, then the same amount every second hour. This has been often tried in the *laryngeal* form, in larger doses, and is of especial utility in this variety of the disease.

Corrosive sublimate, gr.  $\frac{1}{20}$  to  $\frac{1}{12}$  every hour, is a similar but hardly as effective treatment.

Jaborandi is a very new remedy in this trouble. The idea is that when the patient sweats well the membrane will loosen. As it is very depressing, it is not safe unless the patient is quite strong.

Locally, strong caustics have been abandoned. Cleansing, disinfecting gargles are the modern treatment. Carbolic acid, with borax and soda, may be used. Thymol holds a high place, never weaker than 10 grains to the ounce.

R Thymol .....  $\frac{3}{4}$ j.  
Glycerini ..... f $\frac{3}{4}$ ij.  
Aque ..... f $\frac{3}{4}$ iss. M.

Sig.—Gargle. Dilute if necessary.

Permanganate of potassium, a favorite with the English, equal parts of lime water and glycerine, or two parts of the former to one of the latter, are very useful and grateful. When the patient is old enough, these are best used in the form of spray. Equal parts of Monsei's solution and glycerine may be used when the redness and swelling are very great. Do not scrape the membrane.

The most prominent among the solvents for the membrane are lime, bromine and pepsine. Of lime, it is difficult to get enough. Bromine is too irritating. The remedy that has done best is a saturated solution of pepsine in the form of spray.

Lactic acid, jaborandi and numerous other agents which have been used for this purpose, have some solvent power, but not enough.

*Complications or Varieties.*—Fornasari's *diphtheria*, in addition to the ordinary treatment, carried on, if anything, more actively, keep the posterior nares well washed out with—

R Sodii sulphitis .....  $\frac{3}{4}$ ij.  
Glycerini ..... f $\frac{3}{4}$ ij.  
Aque ..... f $\frac{3}{4}$ iv. M.

Pepsine may prove yet more effective. This washes away the membrane, checks decomposition of the same and prevents blood poisoning. Use with the post-nasal syringe.

In *laryngeal diphtheria*, besides the ordinary treatment, the best results have been obtained by having the patient breathe fumes from slaking lime. Also an occasional emetic while patient has sufficient strength, does good.

*Diphtheritic paralysis*, with good management, usually recover. The blood is always deteriorated and patient is anæmic. Give iron, nourishing food, red wines, strychnine, for the paralysis, best hypodermically, if patient is old enough.—*Coll. & Clin. Rec.*

# A NEW PHIMOSIS FORCEPS.

The superiority of the forceps designed by Dr. Briggs of St. Louis, for the operation of circumcision, consists in the simplicity and dexterity of the operation with them; the freedom from hæmorrhage to a great extent, the exactness of the coaptation of the skin with the membrane when sutures are in, which will almost insure healing of the wound by the first intention.

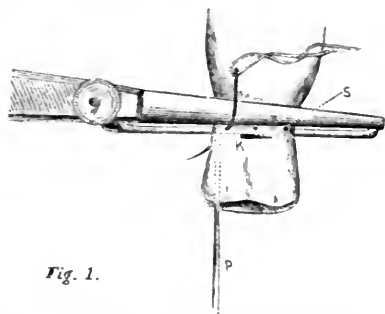


Fig. 1.

Figure 1—Represents the first step of the operation; the forceps in position showing probe within the prepuce laterally, and needle passing to inner side so as to prevent making a suture through the skin only. Any number of sutures desired may be passed, but it is only necessary to have three, which on division of the loop makes six sutures, three on each side.

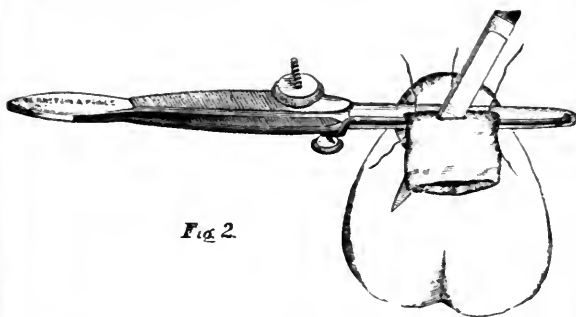


Fig. 2.

Figure 2—Shows sutures in position and foreskin transected above the guide or extra blade.

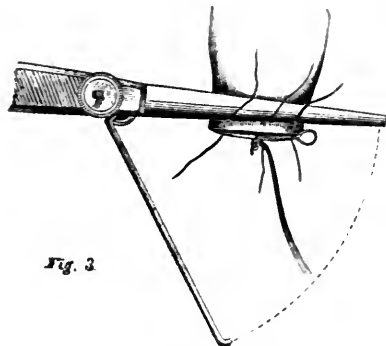


Fig. 3.

Figure 3—Represents the division of the fore-

skin, and hook (a probe or tenaculum may be used) drawing up the loop in the centre or between the membranes. These loops may now be divided and the sutures tied on each side. The forceps being held laterally, obviates any constriction of the membrane in the majority of cases; but should there be any, it can be remedied by dividing the membrane on the dorsum between the sutures.

## THE PREVENTION OF MAMMARY ABSCESS.

Instances are not infrequently met with where the function of lactation is either not considered advisable, as in cases of syphilitic taint, marked tendency to phthisis, epilepsy, etc., or where, from the child being still born, or the nipples depressed, subject to cracks, fissures, or erosions, the function of lactation is unnecessary or unable to be persisted in. Apart from these conditions there is unquestionably a growing tendency for mothers to avoid the responsibility of suckling their offspring. Milk is secreted, and if it be not drawn off at appropriate intervals the breasts become engorged, and not unfrequently inflamed, mammary abscess resulting. From whatever cause it may be, we are often obliged to take steps to prevent such a contingency. For many years the old-fashioned methods in general vogue, if not advocated, were at least tacitly acquiesced in, such as rubbing the breasts with sweet oil, oil and extract of belladonna, glycerin and belladonna, belladonna plasters, evaporating lotions, strapping the breasts, and other like expedients.

It being believed that friction of any kind in the large majority of cases rather tended to produce than prevent mammary abscess, it was long since discarded. The application of a long strip of belladonna plaster, sixteen or eighteen inches long and six or eight inches deep, with round apertures, so as to leave the nipples free, tightly across the chest, the breasts being brought well up towards the median line, for many years was the only resource adopted, beyond careful regulation of the diet, abstinence from fluids, gentle purgation, etc. This method never failed; but it was often found that the smell of the belladonna produced so much nausea in delicate patients as to preclude the employment of it.

Thinking that in all probability the pressure exerted contributed greatly to the advantages derived, Dr. Arthur W. Edis (*Brit. Med. Journ.*, November 7, 1885) was induced to rely upon a few turns of a rib-bandage, or the application of a thin towel or diaper across the chest, the breasts being brought well towards the sternum. Since adopting this method he has never known it fail. Not a single instance of mammary abscess has occurred in a long series of cases, extending over

several years. The only precaution requisite is to apply the pressure on the second day following parturition, before the breasts begin to fill, and to see that the whole of the glands are included.

It is well to elevate the shoulders somewhat more than usual, and not to allow the bed-clothes to cover the upper part of the chest, the sheet alone sufficing to prevent any risk of chill. Restriction as to the amount of fluid for the first few days and attention to the bowels are all that is requisite to insure success. Some little inconvenience—a feeling of tightness or burning pain—is often experienced; but if the pressure be maintained, no harm results, and within the course of a few days the turgescence subsides and the difficulty is at an end. In order to keep the bandage or towel from slipping down, a shoulder-strap from back to front, or merely pinning the bandage to the night dress, suffices.

Where the secretion of milk seems to be unusually abundant, a mixture of bromide and iodide of potassium may be prescribed with benefit. In only a very few instances has it been found requisite to draw off a small quantity of milk by means of a breast-pump or exhausted soda-water bottle, and this only once or twice.—*Therap. Gaz.*

THE TREATMENT OF PELVIC ABSCESS BY INCISION AND DRAINAGE.—Dr. Paul F. Mundé, of New York gives the following conclusions in a recent paper:

1. Pelvic abscess in the female is not very common in proportion to the frequency of pelvic exudations. It probably does not occur in more than ten per cent. of all cases. The majority of cases terminate in spontaneous absorption of the exudate.

2. Pelvic abscess may be extra-peritoneal, most commonly the result of pelvic cellulitis, or it may be intra-peritoneal, the result of pelvic peritonitis. The adhesions in the latter case might make the abscess practically extra-peritoneal. Abscess of the ovary and pyosalpinx did not fall into the division of pelvic abscess proper.

3. In small, deep-seated pelvic abscess, not containing more than two ounces of pus, and in multiple abscesses of the cellular tissue, a permanent cure might be effected by simply evacuating the abscess cavities with the aspirator.

4. About one-half of the abscesses open spontaneously into the vagina, rectum, or pelvic or abdominal wall. These abscesses may heal spontaneously, or they may require surgical interference.

5. Abscesses containing more than two ounces of pus should be opened by free incision, cleared of debris, and drained, if necessary, through a drainage-tube.

6. This incision should be made at the point where pus points most distinctly, usually in the vagina.

7. In a certain number of cases pus points in

the abdominal wall usually at the iliac fossa; and here the drainage-tube would be required.

8. In some cases in which the pus burrowed deeply into the pelvic cavity it would be advantageous to make a counter opening through the vagina, and establish thorough drainage from the abdominal wall into the vagina.

9. Opening a pelvic abscess which points in the abdominal wall does not differ from this procedure in other cases, and is not attended by greater danger when adhesions have taken place.

10. Chronic pelvic abscess—abscess bursting spontaneously and discharging through the vagina, rectum, and elsewhere—might exist many months or years, and prove exceedingly difficult to cure; this is particularly the case when it opens high up in the rectum. A counter-opening should be made in the vagina, for Dr. Mundé doubted the propriety of enlarging the rectal opening even if it were possible to reach it.

11. In doubtful cases, aspirate and establish the diagnosis.

12. The majority of cases of pelvic abscess will recover.

MEDICINES WHICH STIMULATE THE LIVER.—Podophyllin in small doses is a stimulant to the liver. During the increased secretion of bile, the percentage amount of special bile solids is not diminished. If the dose be too large, the secretion of bile is not increased. It is a powerful intestinal irritant.

Enonymin is a powerful hepatic stimulant. It is not nearly so powerful an irritant of the intestine as podophyllin.

Sanguinarian is a powerful hepatic stimulant. It also stimulates the intestine, but not nearly so powerful as podophyllin.

Irisin is a powerful hepatic stimulant. It also stimulates the intestine, but not so powerful as podophyllin.

Leptandrin is a hepatic stimulant of moderate power. It is a feeble intestinal stimulant.

Colocynth is a powerful hepatic, as well as intestinal stimulant. It renders the bile more watery, but increases the secretion of biliary matter.

Jalap is a powerful hepatic, as well as intestinal stimulant.

Menispermmin does not stimulate the liver. It slightly irritates the intestinal glands.

Baptisin is a hepatic, and also an intestinal stimulant of considerable power.

Phytolaccin is a hepatic stimulant of considerable power. It also slightly stimulates the intestinal glands.

Hydrastin is a moderately powerful hepatic stimulant, and a feeble intestinal stimulant.

Juglandin is a moderately powerful hepatic and mild intestinal stimulant.

Chloride of ammonia is credited with chola-

gogue properties, but it is questionable; nevertheless, it certainly stimulates the intestinal glands.

Calomel is a powerful purgative, but whether it stimulates the liver is still *sub judice*.

Corrosive sublimate is a potent hepatic stimulant, but acts feebly on the intestines.

Sulphate of potash is a powerful intestinal irritant, but its action on the liver is variable and unreliable.

Taraxacum is a feeble hepatic stimulant.

Dilute nitro-muriatic acid has a moderate stimulant action on the liver.

Boldo, bromide of potassium, nitrate of potash, and hard soap, have each some stimulant action on the liver.—*Am. Med. Digest.*

**HOW TO ADVANCE MEDICINE.**—Advance in medicine must be looked for by a better insight into the causes of disease: by a study of pathology in its very widest signification, which shall include not only morbid anatomy, but all those changes in the blood and nervous system which often constitutes the *fons et origo malis*. These causes may be found to be of a specific nature, or to exist in the ordinary surroundings of our lives. Of whatever kind they may be, a discovery of their detrimental influence will lead to the means of their removal.

Then, again, much success may be hoped for on making a more complete study of diseases when actually running their course before us, by observing which are the favorable and which the unfavorable circumstances which determine the issue of the case; and not only the surroundings should be noted, but the meaning of the symptoms should be investigated, so as to discover which to encourage and which to oppose.

When we have arrived at some knowledge acquired by these means, the action of drugs may be considered, and the conditions which suggest their employment. As I have before said, it is by no means sufficient to know the physiological action of a medicine, but rather how it will exert an influence on various pathological phenomena. To quote again the instance of digitalis, we require to know not only its action on a healthy heart and arteries, but what power it exerts on quickly acting hearts, for whose correction we now see it daily given.

In upholding these views, I am of necessity protesting against the so-called popular theory, that diseases are so many entities, whose symptoms are to be relieved by some drug: or, as I have seen it expressed in a book on the most wide-spread heresy of the day, that since it has pleased the Almighty to visit his children with various ailments, so he has provided in the herbs of the field some remedy for their cure. This is both an untruth and an absurdity; or, as a member of Parliament declared in the House of Commons, when

denouncing restriction on medical practice, that all collegiate training was useless, the medical art being a gift with which some persons were naturally endowed. It need scarcely be said that he was the patron of the most flourishing quack in the country. If medicine is a branch of science, it must be studied in the same way as other sciences, by observation and experiment. There must first be a study of anatomy and physiology; then a study of disease, as seen in the living subject, and in its results on the dead; then, again, an investigation into the action of remedies of all kinds, and their suitability to the amelioration of morbid states: efficient treatment can only follow by a complete adoption of all these methods. By making it the result of a scientific procedure, we are assisting to stay the degeneracy of medicine, which is ever apt to constitute treatment the very foundation of our art, the alpha as well as omega. — Dr. Wilkes, in *Brit. Med. Journal*.

**THE INFLUENCE OF DRUGS ON MILK.**—In a medico-legal case *MM. Brouardel and Pouchet* were asked whether an infant of two months could have been poisoned fatally through its mother's milk the mother having been for some time under treatment with arsenic, and on several occasions having shown symptoms of arsenical poisoning. To settle the point *M. Brouardel* made a number of experiments by giving Fowler's solution to nursing women, the result of which showed that arsenic can readily be found in the milk, even when taken in small doses, but that no toxic symptoms are likely to be produced in the child unless the mother be taken a toxic dose.

Fehling has lately experimented upon the subject of the elimination of drugs by the milk, and found that salicylate of soda, iodide of potash and iodoform can all be traced to the urine of the nursing, the latter drug when taken in very small quantities, and even when applied externally. Hence he advises against its use as a dressing for wounds in nursing women. He has also found corrosive sublimate in the urine of children whose nurses had the drug applied externally, but the quantity passing to the child was so small that he thinks it unnecessary to use the same precautions with corrosive sublimate as with iodoform. The narcotic substances are without effect upon the nursing. The largest doses of opium or chloral administered to the nurse do not bring about any especial symptoms in the child. Atropine was tried on animals, and no dilation of the pupil or other manifestations occur in the suckling, excepting when the maximum therapeutic dose has been exceeded. Fehling therefore comes to the conclusion that while but few drugs administered to the mother prove deleterious to the infant, a strong exception, however, should be made of those substances that are eliminated with difficulty and accumulate in the

organism. Nevertheless it is certain that many substances, when ingested, produce decided effects upon the milk. "Milk sickness," or the "trembles," occur in persons using the milk of cows which have fed on certain pasturage, and the odor of copaiba or asparagus can be detected in the child's urine when these substances have been taken by the nurse; moreover, artichokes, absinthe, and other substances will make the milk bitter.—*North-western Lancet.*

**DIPHTHERIA.**—With regard to the treatment of diphtheria, I know of nothing too strong to say in the reprobation I think we ought to show towards the treatment by scraping off the membrane; and that by mopping or swabbing the throat with nitrate of silver and other astringents is nearly as bad. It forces the fungus to extend to unstringed portions of the mucous membrane, and drives it downward toward the glottis, and I believe it to have been answerable for multitudes of deaths in former less enlightened days. I believe it is a plan never now adopted, unless it may be by the gentlemen who call all white patches in the throat diphtheria. It is excellent treatment for simple ulcerative tonsillitis.

Arguing from analogy, and seeing the success in vineyards of the use of sulphur for the cure of oidium, I think this is the most rational line of treatment to adopt to destroy the fungus of diphtheria. Finely powdered sulphur blown on to the membrane through a quill or glass tube causes no pain and very little distress to even very young children, and in such cases it is almost the only local treatment that can be adopted. With children a little older, sprays are very useful. Carbolic acid spray is in my experience, useless as a germicide, because the mouth and throat will not tolerate it of sufficient strength to destroy the vitality of the false membrane; but in a strength of 1 in 60, or one in 80, it is very soothing to the inflamed throat. Boracic acid spray, on the contrary, is extremely useful, for it appears to have the power of dissolving the membrane whose vitality the sulphur has destroyed, and thus a fresh layer is exposed for the next applications of sulphur to act upon. Where the diphtheritic patches are very thick, it is a good plan to syringe a concentrated solution of boracic acid over the throat in a child who is too young to use a gargle. If it is swallowed it does no harm. In older children and adults it acts to best advantage as a gargle, removing the membrane in flakes and not irritating the throat. I have not used pepsine, as I have been thoroughly satisfied with sulphur and boracic acid for local treatment; but its use is thoroughly scientific on physiological grounds. We aim, of course, first at the destruction of the local manifestation of the disease in consequence of its tendency to cause death by asphyxia; but it does

not follow that because the throat becomes clean the patient is out of danger. Therefore we ought to aim at the destruction of the poison in the blood from the earliest period of seeing a case. I believe that in the sulpho-carbolates we have a group of substances that are capable, if not of destroying what already is formed there, of preventing a further development of the disease, and so controlling its progress. In the allied diseases of scarlatina and erysipelas it displays marked powers of modifying their course, and, again arguing from analogy, I think it is a scientific proceeding to administer them. I give the soda-salt in doses of a grain for each year of the child's age every three or four hours. The temperature quickly falls, and then the sulpho-carbolate can be discontinued, to be replaced by perchloride of iron.—*Dr. Corbin in Australasian Med. Gazette.*

**KEITH ON HYSTERECTOMY.**—Dr. Thomas Keith, (*Edinburgh Med. Journal*, May, 1885,) while recognizing the marvellous improvements and results of the last ten years in operative interference in cases of fibroids, yet takes a thoroughly conservative view, and advises the operation of hysterectomy only in extreme cases. The removal of the ovaries and tubes, he says, is an operation full of promise, and, as regards his own work, the result is more satisfactory every time that it is performed. It will not, however, supersede hysterectomy, as there are cases in which, even when got at, the ovaries cannot be separated from the uterine tumor without too great a risk. He advises trying the simpler method first, in all cases where the tumor is small, and does not extend much above the umbilicus. The proportion of cases in which interference of any kind is warrantable is, perhaps, not greater than five per cent. The cases in which he thinks hysterectomy may reasonably be recommended are these:

(1) In very large, rapidly-growing tumors of all kinds in young women.

(2) In all cases of real fibrous cystic tumors.

(3) In most cases of oedematous fibrous tumors which are not cured by removal of the ovaries. They occasionally grow to be very large, even weighing two hundred pounds, according to the author. Sometimes, large quantities of red serum can be removed with much relief, and in this way, the patients carried over the menopause when the necessity for further puncturing ceases.

(4) In cases of large, bleeding fibroids, when removal of the ovaries cannot be accomplished, provided that the patient is not approaching the menopause. In these cases, as a rule, though there are many exceptions, menstruation goes on much beyond fifty.

(5) In certain cases of tumors surrounded by much free fluid, the result of peritonitis, provided that the fluid shows a tendency to reaccumulate



after two or three punctures. Occasionally, when the fluid does disappear, its absence may, from some change in the osuosis, be followed by an extremely rapid growth of the tumor. It is important to remember that long continued irritation of the peritoneal surfaces by large, solid tumors, is apt to be followed by degeneration of the peritoneum of a sarcomatous or cancerous nature. The microscopic examination of the fluid will, in such cases, keep one from falling into error. Dr. Keith has several times, where large, healthy, uterine fibroids were present, removed fluids swarming with cancerous elements, the source of which was found to be altogether in other organs affected with cancerous disease. — *Boston Med. Journal*.

**CHIENE'S CONTRIBUTIONS TO PRACTICAL SURGERY.**—Prof. John Chiene, in an admirable series of practical notes on every-day surgery, makes, *inter alia*, the following suggestions:

In wounds of the face, the best stitch to use is horse-hair. Unless the wound is of considerable size, no form of drainage is necessary. The best dressing is a pad of salicylic cotton-wool or corrosive wool, fixed in position with flexible collodion.

The introduction of the sharp spoon into surgical practice has greatly simplified the treatment of lupus. In the use of the sharp spoon, special care must be taken to scrape away the raised edges of the lupoid ulcer, as it is here that the pathological change is advancing. This is best done by scraping from the sound skin toward the centre of the ulcer. After the new formation is completely removed, the best application is a powder which has been introduced into surgical practice by Dr. Lucas Championniere, of Paris. It consists of (1) light carbonate of magnesia, which has been impregnated with the vapor of eucalyptus, (2) powdered benzoine, and (3) iodoform in equal quantities.

In persistent hemorrhage from the nasal cavity, plugging of the posterior nares should not be done until an attempt has been made to check the hemorrhage by firmly grasping the nose with the finger and thumb, so as completely to prevent any air passing through the cavity in the act of breathing. This simple means, if persistently tried, will in many cases arrest the bleeding. The hemorrhage persists because the clot, which forms at the rupture in the bloodvessel, is displaced by the air being drawn forcibly through the cavity in the attempt of the patient to clear the nostrils. If this air is prevented from passing through the cavity, the clot consolidates in position, and the hemorrhage is checked.

In the reduction of a dislocation of the lower jaw, the patient should be seated on a low stool before the surgeon. In this way the surgeon gets a sufficient leverage, standing above the patient, and the reduction of the dislocation is simplified.

In the division of a tight frænum of the tongue, when a child is tongue-tied, care must be taken not to use the scissors too freely. All that is necessary is, standing behind the patient, to nick the anterior edge of the frænum with the scissors, and to tear with the finger-nail the remainder of the band. In this way hemorrhage, which is apt to be troublesome, is prevented.

In the removal of an elongated uvula, after you have grasped the apex of the uvula, it is to be drawn forward and rendered tense before division. If it is simply grasped, and an attempt made to divide it in its normal position, it is not always an easy matter to effect the object desired. When it is rendered tense the operation is a very simple one. — *Ldin. Med. Jour.* Dec. 1885.

**THE DISINFECTION OF SLEEPING-APARTMENTS.**—Professor König of Göttingen, in an article on this subject in the *Centralblatt für Chirurgie*, says that at one time, while he was practising medicine in Hanau, he suddenly discovered that his bedroom was thickly inhabited by bugs. A friend assured him that he could speedily rid him of the pests, and proceeded to fumigate the apartment with corrosive sublimate. The success of this measure was most gratifying; and, when the room was opened, the dead bodies of various kinds of insects were seen strewn about the floor. This incident led the writer to hope that the same means would be effectual in destroying the infectious elements of contagious diseases; and a trial in private houses after scarlet fever or measles, and in hospitals after erysipelas or pyæmia, gave most satisfactory results. Since adopting this method, he has never seen a second case of a contagious disease which could be attributed to infection remaining in the room in which the patient had been confined. The mode of procedure is very simple. From one and one-half to two ounces of corrosive sublimate are put on a plate over a chafing-dish, and then the windows and doors are closed. At the expiration of three or four hours the windows are opened, and the apartment is thoroughly aired. The person entering the room should take the precaution to hold a sponge or cloth over the mouth and nose, in order not to inhale the vapor. The following day the windows are again closed, and some sulphur is burned, in order to neutralize any of the mercurial fumes which may still linger about the furniture and other articles. The room is to be again aired and cleaned, and will then be ready for occupancy.

It should be distinctly understood that this method of disinfection is wholly unsuited for domestic purposes, and should not be employed by persons unaccustomed to chemical manipulations. Corrosive sublimate is a dangerous poison, which it is not prudent to have about the house; and its use in the way here described is safe only in the

hands of a professional "expert."—*Popular Science News.*

**COLD PEDAL DOUCHE FOR CATARRH.**—Medical science often seems to be a compound of contradictions. The hot foot bath, with or without mustard, is a popular remedy for colds, whether of the head or chest. The use of the cold douche to the lower extremities for catarrhal maladies is not so well known, and by no means so frequently advocated. Recently, however, M. Bourgarel has extolled the benefit of the cold douche to the feet in diseases of the respiratory passages. As all the world knows, the object of the pedal excitant is the production of *reaction*. M. Bourgarel maintains that reaction is easily obtained by the application of cold, and for this purpose the douche need not be very forcible or long applied. It is recommended that the cold douche to the feet be systematically used. There can scarcely be a doubt of the value of this treatment, provided the cases in which it is prescribed are suitable. As a general tonic to the circulatory and nervous systems, the application of cold water under some pressure to even a small area of the superficies of the body stands in a high place. The beneficial effects on the system at large reflects itself on those parts which are in a less healthy or atonic state. And so it follows that the remedy in question may put the finishing stroke to a chronic catarrh. That the temporary shock and subsequent reaction implied in the cold douch may also prove of service in spasmodic attacks is not without the bounds of physiological reason.—*Lancet.*

**THE TREATMENT OF PNEUMONIA BY QUININE.**—DR. F. P. ATKINSON thus writes in the *Practitioner* for October:

If the Collective Investigation Committee of the British Medical Association have done no other good, they have certainly directed attention to the treatment of pneumonia by quinine, which is destined, I think, sooner or later to supersede all methods now in vogue. There can be no question that in almost every case (and I think there are very few exceptions), it prevents the disease advancing beyond the first stage, and rapidly causes resolution to take place. It does away with the necessity for poulticing, all that is required being the application of cotton-wool to the front and back of the chest. My friend, Mr. Corbett, who has a good series of charts to bring forward, tells me it is equally successful in cases arising in young infants as it is in adult cases, and he asserts that many children he has been able to pull through, who, in old times, would certainly have been lost.

He gives an adult two grains every two, three, or four hours, according to the severity of the case, combined with hydrobromic acid, and if there is any delirium a few drops of tincture of digitalis.

If there is any large deposit of urates in the water, he gives some citrate of potassium alternately with the quinine. This method of treatment I have followed out with decided benefit to my patients and satisfaction to myself. Now any one who has given repeated doses of quinine to a patient will, no doubt, have noticed the profuse sweating that occurs after its administration, and I am anxious to find out as to whether quinine really acts curatively through the perspiration it produces, its antiseptic action, or both. In some cases of menorrhagia, it exerts a very decided influence upon the muscular tissue of the uterus; has it any influence upon the muscular coat of the arteries in pneumonia? An answer to these questions would, no doubt, help us not only in the treatment of pneumonia, but also many other febrile diseases.

**TOLU VARNISH IN DIPHTHERIA.**—Dr. Richard Lord writes in the *Brit. Med. Jour.*, December 12, as follows: "M. O. L., aged 13, complained, at 2 o'clock on November 10, malaise. She was in bad spirits, owing to the death of one of her schoolfellows from diphtheria. A saline asperient was ordered and taken in the evening. Next morning, at 7 o'clock, said she felt all 'right,' but complained of sore throat.

"On examination, a thick, well-formed, greyish-looking patch, rather smaller than a florin, but of oval shape, with gangrenous edges, was seen over the right tonsil, and on the right posterior pillar of the fauces. At 5 o'clock in the afternoon, the patch had somewhat increased, and two small patches were seen on the other side. The diphtheritic spots were covered with tolu varnish, as recommended in Dr. Morell Mackenzie's work. Tincture of perchloride of iron, with glycerine and and chlorate of potash, was prescribed as a constitutional remedy. The patient expressed herself greatly relieved by the varnish, and I applied it twice a day, instead of once as advised by Dr. Mackenzie. In about forty-eight hours from the time when it was first seen, the membrane began to disappear, and, on the evening of the fourth day not a trace of it remained.

"I may add that it is important that the fauces and tonsils should be first well dried with blotting-paper. The solution can be most conveniently applied with a camel's hair pencil fixed in a long wooden pen-holder, as supplied by Messrs. Maw. The method of treatment which I have found so successful in this case being, I believe, little known, I think I shall be doing a service to my brother practitioners in placing it on record.

**SUBCUTANEOUS DIVISION OF THE SPHINCTER ANI.**—In the *Med. Times and Gazette*, Mr. Pick recommends the plan of dividing the fibres of the sphincter ani by a subcutaneous incision, in cases of spasm of the rectum and fistula in ano. The

author records the case of a man who suffered from intense pain and spasmodic contraction of the sphincter ani after each action of the bowels. No structural lesion could be detected, and it was determined to divide the sphincter subcutaneously. This was done by inserting the left forefinger into the rectum, and then introducing a tenotome through the skin about a quarter of an inch from the anal orifice; by means of the finger in the rectum, the point of the tenotome was carried up beneath the mucous membrane, until it was well above the upper edge of the sphincter muscle. The tenotome was then turned round, and the fibres of the muscle were divided until no resistance remained. After the operation, the patient's bowels were confined for 48 hours by means of opium; then a copious enema was given, producing a good evacuation without any pain. From this time, the patient was perfectly relieved of his trouble. The author also records three cases in which he has divided the fibres of the sphincter ani in this manner before operating for piles, and considers this a better plan than that of forcibly stretching the sphincter with the hand. *Med. and Surg. Reporter.*

**RELIABLE REMEDY FOR OZENA.** Besides the removal of the diseased bone, the only remedy which has thus far been considered to possess any value in ozena has been chloride of zinc, and every physician will admit that its effect never answers the expectation.

A new preparation of aluminium, the aluminium acetico-tartaricum, has been discovered to be almost a specific in ozena. Altenstark and Schaefer (*Deutsche Med. Woch.*) 23 85,) have tried it in a large number of cases, and say that its effect is really surprising. The fetor of the secretion rapidly disappears, the scabs become thinner under its use and drop off much easier, the atrophic mucous membrane assumes a healthy look, and within two weeks a complete cure may be established in all cases where the bone has not already been so diseased as to be loose like a sequestrum. Of a fifty per cent. solution, one teaspoonful is usually added to one-half to one pint of water. It possesses about the same caustic properties as a solution of nitrate of silver of one to five, and is also indicated in the same morbid conditions of the mucous membrane as the latter drug, but it seems to have a specific effect upon the mucous membrane of the nose and of the larynx. In ulcerations, for instance, of the larynx, its effect is far more rapid than that of boric acid.

We do not know whether the remedy has reached this country, but it will be rapidly imported whenever some of our leading physicians conclude to make a trial of it.—*Med. and Surg. Reporter.*

AMMONIA IN THE TREATMENT OF ANTHRAX

**ANE CARBUNCLE.**—The *Lancet*, for January 9th, without giving the source of its information, states that Dr. Leonidas Avendano lately read a paper before a Lima medical society, in which he testified to the great value of ammonia in anthrax and "carbunculous diseases," adding that it was a specific, and should be the only drug used. In cases of malignant pustule, after an incision has been made, the official solution should be dropped into the wound, in the hope of its destroying the bacilli there, and of some of it finding its way into the blood before the bacillus does so as to make it impossible for the parasite to multiply in that fluid. In addition, some salt of ammonium, such as the acetate, should be given internally, and, on the slightest suspicion of general infection, resort should at once be had to intravenous injections of ammonia, in doses of ten drops of the official solution with the same quantity of distilled water. In cases of malignant oedema and carbunculous fever, too, "the microbe should be attacked directly in the blood, ammonia being injected into the circulation." Several successful cases were related, and the author closed by stating, to the honor of Peruvian medicine, that Dr. Leno Alarco had first injected chloral in tetanus, and ammonia in septicæmia or purulent infection; that Dr. Armando Vélez and Dr. F. P. del Barco had first injected capsicum into the veins in yellow fever; and that Dr. Néstor Corpancho and himself had originated the treatment described for carbuncle.—*N. Y. Med. Journal.*

**TESTA ON IODOFORM IN GOUT.** Professor Testa (*Gaz. Med. di Torino*, 1885) recommends the use of iodoform in gout. From several experiments and clinical observations, he arrives at the following conclusions: 1. Iodoform augments the daily excretions of urea, while it accelerates the organic changes of matter and the process of oxidation. 2. The quantity of uric acid which is excreted daily with the urine, under the use of highly nitrogenized food, is diminished, inasmuch as, through acceleration of the process of oxidation, the conversion of uric acid into urea is increased. Oxaluria is diminished, through conversion of the oxalic acid into carbolic acid and water. 4. In gout, the amount of uric acid in the blood is diminished through an increase of the organic changes. 5. Hence iodoform is to be regarded as a rational remedy, fulfilling the primary indication in gout. The quantity of iodoform given daily by Dr. Testa amounted to from sixteen to twenty centigrammes ( $1\frac{1}{2}$  to 3 grs.). In seven cases of gout in which it was given, the paroxysms became less frequent, and their intensity and duration were reduced. It appears, however, to be contra-indicated, or at least to require great caution in its use, in cases where gout is complicated with an affection of the kidneys.—*London Med. Record.*

**CARBON DISULPHIDE IN NEURALGIA.**—Guerden recommends, as far superior to the menthol pencil in neuralgia, the application, for three minutes, of:

Carbon disulphide (rectified) . . . . .9 parts.

Essence of mint . . . . .1 part.

Shake well.

In superficial neuralgias, whether facial, dental, or intercostal, and in superficial rheumatic pains, this application produces instantaneous relief, and not unfrequently a cure. In the deep neuralgias, as sciatica, it is necessary to project the solution upon the painful part by means of an atomizer. Actual freezing of the skin is unnecessary. Dental neuralgia usually succumbs to this treatment applied to the corresponding cheek—a slight application to the gum, or the insertion into the carious tooth of a pledget of cotton moistened with the solution being occasionally advisable. Very obstinate facial, dental, and pharyngeal neuralgias may be subdued by gently introducing into the external auditory meatus a pledget thus moistened, squeezed out, and covered by a layer of dry cotton.

—*Revue de Therap.*

**THE ACTION OF MERCURY UPON THE BLOOD.**—Dr. L. Gallard, in an experimental study to determine the action of mercury upon the blood, concludes:

1. That the number of the red corpuscles may diminish slightly at the beginning of the administration without regaining their original proportion, but more frequently it increases progressively, until about the fourteenth day of treatment, to undergo at this time a slight diminution.

2. The hæmoglobin always increases progressively until about the twenty-fourth day of treatment, and having attained at this time its greatest abundance descends to its original proportions, and if the treatment is continued sinks below it.

3. The abundance of hæmoglobin increases in a proportion beyond that of the red corpuscles, and may even increase when these diminish, whereby mercury may be compared to those metals which induce the production of hæmoglobin.

4. The weight of the body increases almost constantly, though it is impossible to determine the exact relation which exists between such increase and the condition of the blood. —*Archives Générales de Médecine*, November, 1885.

**TREATMENT OF FAVUS IN THE ADULT.**—The crusts should first be removed by lotions of green soap, preceded, if necessary, by poultices. The hair is then to be cut as short as possible, and an ointment of eight to fifteen grains of bichromate of potassium in one ounce of lard applied, the head being afterwards covered with a cap of linen or cotton cloth. The head should be thus washed with green soap, and covered with the ointment every morning and evening. If the application

caused much smarting the proportion of potassium bichromate should be reduced, or if the crusts fail to become detached it should be increased. A trial of a few days duration will suffice to determine the relation between the individual tolerance and the degree of activity of the ointment. The hair should be cut very close, but epilation is useless.—*Journal de Médecine de Paris*, November 15, 1885.

**GOSYPIUM IN UTERINE HÆMORRHAGE.**—MASONI ("Korrespondenzbl. f. Schweiz. Aerzte;" Ctrbl. f. klin. Med.") thinks that this drug is to be regarded not only as an efficient substitute for ergot, but as having some advantages over that remedy. Although less prompt in action, it is more enduring; hence, while it has been used successfully to increase the pains of labor and in uterine atony in the placental stage of labor, its most appropriate field is in gynecological practice. In two cases of metrorrhagia at the menopause the author observed brilliant results from the use of the fluid extract, two or three teaspoonfuls daily.—*N. Y. Med. Journal*.

**ASTHMA.**—Dr. Q. C. Smith in a recent number of *Gaillard's Medical Journal* recommended the following for the paroxysms of asthma:

R Mur. Pilocarpine,

Apomorphia . . . . . aa gr.  $\frac{1}{2}$ .

M. To be administered hypodermically.

The patient will quickly sweat profusely, breathe easier and obtain sleep in ten minutes.

For the constitutional treatment he uses the following:

R Iodide of sodium . . . . .  $\bar{5}$  l.

F. E. grindel. robuus,

Tr. aloes . . . . .

Syr. ipecac . . . . . aa  $\bar{3}$ ij.

Liq. pot. arsenitis . . . . .  $\bar{3}$ ss.

F. E. belladonna . . . . . gtt iv.

Syr. Lactucarium, (ambergris) q. s. ft. . . . .  $\bar{3}$ ij.

S.—Teaspoonful every three hours for one day, and three times a day after meals for from three to six weeks.

**A NEW HEART-TONIC.**—Prof. Wagner recently employed the new heart-tonic, the nitro-salicylate of caffeine, in his clinic in Buda-Pesth, on twelve patients (*Orosi Hetilap.*, No. 32, 1885). The daily dose varied from 3 to 18 grains. The results were the same as those observed by Riegel. The remedy is a rival of digitalis, but has the great advantage of being more rapid, and never accumulative in its effect. The only drawback seems to be, that with the discontinuance of the remedy its effect also quickly ceases. At the beginning but small

doses should be administered, as many patients evince a peculiar idiosyncrasy against the drug.

The remedy is indicated in all cases where compensation has ceased. It here causes a regular and stronger action of the heart, and decided increase of the urinary secretion. All the disagreeable after-effects of digitalis are absent in the employment of nitro-salicylate of caffeine. — *Med. and Surg. Reporter.*

**THE TREATMENT OF SCARLET FEVER.**—Dr. Bedford Brown, of Alexandria, at the meeting of the Medical Society of Virginia, said that he had seen malignant cases with cold extremities and tongue, with a body temperature of 107° F. He used

R. Acid. salicylat. . . . . ʒij  
Tinct. aconit. radice. . . . . gtt. xlj  
Infus. digitalis . . . . . ʒjss  
Spts. ammon. aromat. . . . . ʒijj  
Syr. aurant. cort. . . . . ʒss  
Aquæ, . . . . . ʒj

M. Sig.—Teaspoonful for a child five years old every three hours.

This combination reduced fever more decidedly than any other antipyretic he had used: it acted also as a diaphoretic and diuretic. A tepid bath or a wet pack increased its action. Alcoholic stimulants benefited malignant cases, tending to collapse and coma: as also cases, on the other hand, having high fever, rapid pulse, and extreme restlessness. Such agents, also, generally arrested adenitis. In dangerous cases, frequent baths were too exhaustive. When extensive suppuration and pyæmia threatened, tincture of iron, Fowler's solution, and quinia sulphate acted well. To arrest acute nephritis and renal dropsy, he enveloped the body with a flaxseed-meal poultice covered with oil-silk. When the kidneys were engorged, the urine bloody, with dropsy of the chest and abdomen, a full dose of calomel, followed by compound powder of jalap, would often do good. Such cases bore purgation. But if the renal dropsy was attended with cool skin, great pallor, feeble pulse, and great prostration, then frequent purgation was not well borne. In such cases he used lumbar poultices, digitalis, acetate of potash, with occasional saline cathartics. A morbid element in scarlatina often developed rheumatism: hence, frequent cardiac complications. When these occurred, he resorted to the active agents named in the foregoing prescription. Alkalies and salines should be used in renal complications. He had been disappointed with the diaphoretic action of pilocarpin. Potassium iodide was often useful in nephritic sequelæ of scarlet fever. — *N. Y. Medical Journal.*

**TO PURIFY DRINKING-WATER.**—Professors Austen and Wilber, after the most elaborate experi-

ments, consider it established that by the addition of two grains of alum to the gallon, or half an ounce to the hundred gallons, water can be clarified by standing, and that neither taste nor physiological properties will be imparted to it by this treatment. By increasing the amount of alum, the time required for separation and settling can be diminished; and, *vice versa*, by diminishing the amount of alum added, a greater time will be required for the clarification. The solution of alum is made as follows: Dissolve half an ounce of alum in a cup of boiling water, and when it is all dissolved pour into a quart measure and fill to a quart with cold water. This solution should be kept in a bottle labelled "alum." Fifty-four drops of this solution contain two-thirds of a grain of alum, which is the amount to be added to one gallon of water. The old-fashioned teaspoon holds about forty drops, the new spoons, however, hold about seventy drops. Hence a modern teaspoon, scant full, will be about the right amount to add to every gallon of water to be filtered. — *St. Louis Cour. Med.*

**THE DOCTOR'S PECULIAR DANGER.**—The *Medical Age* deals with a delicate subject in the following skilful manner: "The physician, especially if he has been favored by nature with physical attractions, is above all men subject to sexual temptations. His relations to his female *clientèle* are of that secret and confidential nature which tends to familiarity. Weak women, who are diffident and shy to all other males, frequently conceive for their physician a passion which it would require but a slight response to convert into a crime. We apprehend there are few of our readers whom professional experience has not convinced of this frailty (which may, after all, be more or less physiological) on the part of the weaker vessel. In view of this fact, it is very complimentary to the profession that there are so few scandals chargeable to it. As compared with even the clergy (the especial conservators of morals), physicians stand well in this respect. Doubtless, too, not a few of the scandals chargeable to medical men have no sufficient foundation, the peculiar relations of the doctor to his female patients laying him especially open to the schemes of the black-mailer."

**FACIAL PARALYSIS.**—To a recent meeting of the Midland (England) Medical Society Dr. Suckling showed a man, aged twenty-six suffering from facial paralysis with inequality of soft palate and deflection of the uvula. Two years ago he was thrown out of a trap on his head. Purulent discharge followed from both ears some weeks later, ending in absolute deafness and facial paralysis on the right side. The faradaic and galvanic irritability were quite lost, the uvula was deflected to the right, and the posterior pillar of the fauces on the

left side was much narrower than on the right. Dr. Suckling considered the palatal changes very interesting, since Dr. Gowers says he has never seen the soft palate affected in facial paralysis.

**NAPHTHALIN IN THE TREATMENT OF ULCERS.**—According to Dovodtchikow (*Wratch*, 25, 1885), naphthalin forms a most valuable local application to ulcers, especially in patients of the poorer class. Apart from its cheapness and the ease with which it may be applied, it is recommended as inducing rapid healing and cicatrization, and as possessing such antiseptic properties as to cause the rapid disappearance of offensive odors. A still more important claim is that the application is absolutely painless and non-irritant, so that the patient thus treated may continue his work without retarding the cicatrization of the ulcer.—*L'Union Médicale*.

**NUX VOMICA IN RECTAL PROCDENTIA.**—During the past ten years Schwartz has successfully used the extract of nux vomica in rectal procdentia, also in infants and adults, even when the trouble has become chronic. One and one-half grains of the extract are dissolved in eight ounces of distilled water, and of this from seven to ten drops are taken every four hours. The dose for a child is given as five drops and for an infant of one to two years the dose is two to three drops. A recent prolapse should succumb in from twenty-four to forty-eight hours. To prevent relapse this treatment is continued a week after cure, the appropriate dose being taken but twice daily. If the prolapse is not of recent date, sixty grains of extract of rhatany may with advantage be added to the original solution.—*Nouveaux Remèdes*, Dec. 1, 1885.

**CARBOLIC ACID IN INDIGESTION.**—I have just passed through a severe attack of indigestion accompanied by colic, pyrosis, food eructations, epigastric weight, uneasiness, etc. Alkalies, muriatic acid, pepsine, and pancreatic extract failed to give relief. Seeing your note in the *American Practitioner* on the use of carbolic acid in acid eructations, etc., I took, with almost instant relief, two or three drops of the acid as soon after food as regurgitation, distension, or acidity occurred. One dose was usually sufficient. On two occasions only was a second dose required. This I took half an hour after the first. I dropped the acid on a bit of fresh bread and rolled the mass into a pill. Since my own case, I have given it in a similar case with like good result. Here I added a scruple of carbolic acid to one ounce of glycerine. Dose, a teaspoonful.—R in the *Am. Prac. and News*.

**EVOLUTION IN MEDICINE.**—The steady progress which medicine has made from year to year for the last half-century has transformed the physi-

cian's art, and contributed largely to diminish the weight of human misery and disease; of this we are not unfrequently reminded by veteran physicians who can look back for this period, and to whom the subject, as published addresses and orations show, has an irresistible attraction. To trace the upward course from year to year, to lay a finger upon this fact or that, and say here is something known now but not known a year ago, is less convincing; for the science and art of medicine does not advance by leaps and bounds, but by a slow process of accretion strictly analogous to organic growth. The tendency of medicine in this generation is primarily toward analysis; the analytical method has been applied to every department, and a minute accuracy and precision of observation has been cultivated.—*British Medical Journal*.

**HOW TO REMOVE SMALL BODIES FROM THE EYE.**—The eye is frequently irritated by the entrance of bits of straw within the lids. If a grain of flaxseed is placed under the inferior eye-lid and the eye closed, it immediately becomes surrounded by a thick mucilage which entraps the foreign body, and soon carries it out from the angle of the eye.—*Med. World*.

THE knowledge a trained nurse possesses—the very utmost she can acquire—must be simply so much quackery, in so far as it extends beyond the mere womanly qualification of ministering gently to the sick and obediently carrying into effect a careful practitioner's instructions. Unhappily, female nurses are actually allowed to pass catheters and give hypodermic injections.—*The Lancet*.

**PRURITUS OF PREGNANCY—PILOCARPINE.**—A correspondent writes that a single dose of one-third of a grain of pilocarpine by the mouth, served to bring on profuse sweating and salivation, with complete relief of intolerable and persistent itching which had lasted throughout pregnancy and recurred after delivery.—*Brit. Med. Jour.*

**HYPERTROPHY OF THE HEART.**—Prof. Da Costa recommends in the initial stage:

R Tinct. aconiti rad. . . . . m xvi.  
Tinct. cinchonæ comp. . . . . ʒij.

M. Sig.—One teaspoonful three times a day.

In addition, the bowels are to be kept freely open, and the arterial tension lessened by the administration of one or two drachms of Rochelle salts, or some other saline, every morning.—*Med. Bulletin*.

**TELEPHONES FOR THE SICK-CHAMBER.**—A London firm has devised a telephone by which persons suffering from contagious disorders may safely communicate with their friends.

# THE CANADA LANCET.

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## BACTERIA.

It may be interesting to our readers to have set before them in a short space the principal facts known to the scientific world in regard to bacteria, these little organisms which have so interested the medical mind in connection with their relation to disease. The subject is one of immense importance, and some of the best scientific minds of the day are bent upon the task of investigating the true position of these organisms, whether they stand in the relation of cause or effect to those diseases with which they have been especially associated.

But few investigators look at present with favor upon the theory that disease is caused by chemical changes—i. e., that some *materies morbi* having found its way into the body, sets up a catalytic action and induces morbid processes in the various tissues which are affected in the particular disease. This is, speaking broadly, the idea which held the medical mind for years, and which even yet has a few well-known adherents; but the great majority of scientists and original investigators unhesitatingly affirm that disease is caused by living organisms, germs, which introduced into the system multiply indefinitely and thus excite the morbid processes characteristic of each type of disease.

This germ theory of disease is certainly the one which commends itself to the present bent of the scientific mind. When Koch announced in 1882

that he had discovered the bacillus which was specific in tubercle, he gave a great impetus to the investigations then being made as to the influence of bacteria upon disease. These investigations, owing to the imperfection of instruments, the ignorance of the methods of staining, and the want of precise information on the part of botanists regarding these schizomycetes, had been carried on in a desultory manner for years. Bassi discovered, as early as 1835 the cause of muscadine in silk-worms. The fungus of favus was discovered by Schonlein in 1839, that of thrush a few years later: so that though it is only within the past few years that much progress has been made in the investigation, it was commenced long enough ago.

The term *bacteria*, synonymous with *microbe*, has been given to microscopic particles of vegetable matter belonging to the *fungi*. These little organisms are practically omnipresent. Every breath we draw sucks almost countless numbers of them into the lungs. Examine a drop of decomposing animal fluid under the microscope, and you will find the fluid alive with minute particles of various shapes. Some mere points, others rod-shaped, others wavy lines, and all in a state of motion. Wherever decomposition goes on, these bodies are found; the air of our towns is as a sea in which they float in immense profusion, while even country air is not free from them, all awaiting favorable conditions for reproduction. The power of resisting destruction shown by most of them is great. Boiling water will not destroy all forms, e. g., *B. subtilis*; they may be subjected to freezing without losing the power of motion and reproduction. Fortunately however, the temperature of boiling water destroys all known pathogenic species. The name *Bacteria* is unfortunate, being the proper name of a single genus only, but it has come into general use and is now used in the same sense as *microbe*. They have been classified by Cohn, who calls them as follows:

1. *Sphero-bacteria* or micrococci. 2. *Micro-bacteria* or bacteria. 3. *Desmo-bacteria* or bacilli. 4. *spiro-bacteria* or spirilla.

The first consist of minute drops of protoplasm, having delicate cell walls; they multiply by fission, forming clusters (*zooglea*), and chains. They are found in myriads wherever moist organic matter is decomposing, and are active agents in the process



of fermentation. The majority of these germs are innocuous, but some are pathogenic.

The second, *micro-bacteria*, *B. termo*, are slightly elongated, multiply by division, and often appear linked in chains. They are remarkably active, and while many of them are harmless, the bacterium septicæmiæ is rapidly fatal when introduced into the blood of a living animal. Others having a close resemblance to the pathogenic members of this class are found in the blood of persons in perfect health. The third, *Desmo-bacteria* (bacilli) are of various sizes, but all are more or less rod like. The long slender ones have been spoken of by authors as vibriones. They are sometimes provided with a flagellum or tail, which assists in movement. Their development is usually by spores, though fission has been observed. The *Spiro-bacteria* appear under various forms, but all have a characteristic twist or spiral. Some are provided with flagella, which assist in locomotion. They multiply by spores. While the principal forms have thus been spoken of, it is to be remembered that no hard and fast line can be drawn between them. They do not always retain their original forms; thus the micrococci often elongate so as to resemble the bacilli; and the bacilli sometimes break up into fragments so as to closely simulate the micrococci.

These little organisms are found in every portion of the universe where their existence can be maintained, and it is fortunate that only a few are pathogenic. "Their prodigious powers of reproduction, their astonishingly rapid alterations of the media in which they multiply, and the occult and subtle chemistry which they employ, these and other mysterious facts of their life history are subjects of profound concern." Many act as scavengers, hastening disintegration by oxidation, while others, if the theory be true, are the active agents in disease. All bacteria do not require oxygen for their existence, but all need water, without which they become inert.

Certain temperatures are necessary for the successful multiplication of these fungi, that of the body being most favorable for the pathogenic varieties, but while prolonged boiling is fatal to all known species except *B. subtilis*, their spores are less easily destroyed, though the question appears to be open, as to whether they will resist prolonged boiling, and in sterilizing for the purpose of pure

culture they are exposed to prolonged high temperature in an oven.

Some of the diseases in which specific bacilli have been isolated are as follows: tubercle, cholera, anthrax, septicæmia, typhoid fever, carbuncle, glanders, small-pox, syphilis, gonorrhœa, diphtheria, etc., etc. Recent observers have discovered minute organisms in the red blood corpuscles of persons suffering from malaria. They can be easily stained and indeed present all the chief characteristics of bacilli. They have been named plasmodes, and when injected into the blood of a healthy individual speedily produce febrile movement. The scientific world is now much interested in bacteriotherapy, and several experiments recently made seem to shadow forth the hope that much may yet be accomplished in the cure of specific disease by the destructive action of one species of bacillus upon another. Thus Cantani's phthisical patient who was subjected to inhalations of *B. termo* in meat broth, soon showed in his sputa total absence of *B. tuberculosis*, and had his condition "*wonderfully improved*." Salama of Pisa, found a similar disappearance of Koch's bacillus and improvement in a patient's condition, under the influence of the same *B. termo*.

Of course it is not certain that in either case the bacterium was the only means by which improvement was brought about; but it is sufficiently encouraging to permit us to hope that bacteriotherapy may yet be of service in the prevention and cure of disease. Let us however, be on our guard, and not allow this most inviting theory to carry us too far, for it must be remembered that we are by no means certain that we have discovered in these organisms the cause of certain obscure pathological states; that the bacteria may not be the cause, but the result of disease, whereby the soil becomes fit for their multiplication and growth; in fact *whether they are the cause, or the scavengers of disease*.

#### AMERICAN HEALTH ASSOCIATION.

We wish to inform our readers that it has been decided to hold the fourteenth annual meeting of the American Public Health Association in Toronto early in October, 1886. The Association dates from 1872, and from a very modest beginning has grown so rapidly in importance and numbers that

it now reckons among its members, not only medical men from every State in the Union, but numerous laymen-clergymen, lawyers, architects, journalists, etc., etc.

The following are some of the officers for the present year: *President*, H. P. Walcott, Cambridge, Mass.; *1st Vice-President*, Dr. C. W. Covernton, Toronto. Dr. Hingston, of Montreal, is the representative of the Advisory Board for the Dominion of Canada; Dr. P. H. Bryce, for Ontario, and Dr. Montizambert, for Quebec.

Associated with this organization is one of all the State Boards of the Union, and at the last meeting, the Provincial Boards of Ontario and Quebec were represented. National, State, and Municipal health organizations have a large representation in its membership, and this taken in connection with the extent and practical value of its labors, has gained it a standing recognition and influence all over the United States, and now that the Dominion of Canada is included in its organization, it may be fairly claimed as the largest sanitary association in the world—the International Congress of Europe not having so large a membership or embracing anything like the same amount of territory. In view of the very great advantages to be derived by officers and members of Boards of Health, Provincial and Local, it is to be hoped that not only the Medical Health Officers of Local Boards, but the Chairmen and Secretaries will join the Association. We have reason to know that the present Central Board represented at the P. H. A. at Washington by Dr. Hingston, will send delegates, and also that the Provinces of New Brunswick, Nova Scotia and Prince Edward Island will send their fair share. It would therefore be a matter for very great regret if the Local Boards were not adequately represented. We have reason for saying that the Provincial Board will do their utmost to make the attendant expenses as light as possible. Efforts are being made to secure a representation from Europe, and to the furtherance of this end, arrangements have been made with the S. S. and R. R. companies to carry passengers at the same rates as were accorded to the members of the British Association when they visited Montreal.

**HYDROCHLORATE OF COCAINE IN REMOVAL OF THE TONSILS.**—Dr. W. C. Phillips, (*The Quarterly*

*Bulletin*) has used with the following results a two per cent. solution of the Hydrochlorate of Cocaine in the removal of the tonsils. Only one tonsil was treated with the solution, the other was removed without recourse to anæsthesia. In the case in which the solution was applied, it was noticed: 1. That no hemorrhage occurred for a few seconds, and that it was at no time profuse. 2. That there was very little sensation of choking on the part of the patient. 3. That the cut surface was more than ordinarily anæmic in appearance. In the other case, which was the smaller tonsil of the two, more choking was noticed, the hemorrhage was more profuse and instantaneous, and the cut surface of the tonsil was redder than on the other side. From the above results he is led to conclude that the uses of Cocaine in cases requiring excision were: 1. To lessen the hemorrhage. 2. To do away with the choking sensation. 3. To relieve the pain caused by the operation.

**THE ACTION OF LACTIC ACID ON CERTAIN MORBID GROWTHS.**—Lactic Acid has been proposed by Dr. E. Jelinck, who has been studying its action for some months, as an application to granulations occurring about the nares, pharynx and larynx. So much benefit has followed its use that he considers that it will play an important rôle in the treatment of tubercular diseases of the larynx. For the larynx a 20 per cent. solution is strong enough to begin with. On the pharynx an 80 per cent. solution may be used, and on granulations elsewhere it may be employed in powder or as a paste allowed to remain on the part for twenty-four hours, the application being repeated in three days. Professor Mosetig-Moorhoff has employed it on fungus (of bones), lupus, papilloma and epithelioma. Two cases have been exhibited by him before the Gesellschaft der Aerzte of Vienna, in which there was in each case extensive involvement of bones, yet in each case a beautiful cicatrix had been obtained.

**POST MORTEM ALBUMINURIA.**—It has been found by M. M. Vibert and Agier that urine drawn from the bladder of a cadaver is almost invariably albuminous, even when there was no lesion discoverable in any part of the uro-genital apparatus. It was noticed in these experiments, also, that the longer the time was since death occurred, and the less urine there was in the bladder, the greater was

the proportion of albumen contained in it. The source of these cases was shown to be the mucous membrane of the bladder, for when the bladder was removed from the cadaver, emptied of its contents and washed, and then filled with distilled water, this fluid was found in a short time to be markedly albuminous. This is a point well worth bearing in mind in the examination of the bodies of those who have died suddenly.

**APPOINTMENTS.**—The Ontario Medical Association has been requested to appoint two of its members on the committee appointed at the International Congress, Antwerp, to report on the best bases of International statistics of the insane, and classification of mutual diseases. The representative for America is Clark Bell, editor of the *Medico Legal Journal*, New York, and he has requested two to be named by each of the scientific societies in America, to assist him. The President, Dr. Tye, has named Dr. Bucke, of London, and Dr. C. R. Clark, of Kingston, as our representatives.

Dr. D. W. Eberts, McGill College, Montreal, has been appointed medical superintendent of the Winnipeg General Hospital. Dr. P. Wells has been appointed member of the Quebec Board of Health, Quebec, and Dr. C. S. Parke, commissioner of the Marine Hospital, Quebec, *vice* Dr. Marsden deceased.

**TRYPSIN IN DIPHTHERIA.**—This remedy which has been recently introduced by Messrs Fairchild Bros. & Foster of New York, is highly extolled in the treatment of diphtheria. It acts quickly and powerfully as a solvent of fibrin and fibrinous membrane. This property gives the strongest grounds for anticipating success in its application. It is most active when rendered slightly alkaline. We give the following formula for its use.

R Trypsin ..... grs. xxx.  
Sod. bicarb..... grs. x.  
Aque Dest..... ℥j M.

It is used locally and may be applied in the form of spray, or by means of a brush every hour or half hour.

**THE METRIC SYSTEM NOT THE BEST.**—We see that Oscar Oldberg (*National Druggist*) has, after advocating the metric system for a number of years, at last decided against it. He believes our present system of weights and measures is better

adapted to the purposes of medicine and pharmacy than the metric, because of the inconvenient size of the units and the impossibility of binary subdivision in the latter. No doubt this decision will please most of us, who, though we may talk and write glibly enough of grammes, litres, etc., have not the same "grip" on the meaning of the words we have on grains, pints, etc., learned in our school-boy days, and made tangible by every day experience. The metric system is more scientific, but to an English speaking people it is not so satisfactory as our old Apothecaries' and Troy weights, or our gills, pints and quarts.

**ONTARIO MEDICAL COUNCIL ELECTION.**—By reference to our advertising paper, it will be seen that an election will shortly take place, of a representative for the Territorial Division of Saugeen and Brock, on the Medical Council, made vacant by the death of Dr. Douglas. Dr. Geo. S. Herod of Guelph, has offered himself as a candidate, and if elected will make an excellent representative. He is well known in the community and so far as we can gather from his circular, he is in accord with the profession, in regard to the management of the affairs of the Council.

**MEDICAL SOCIETY OF THE STATE OF NEW YORK.**—The eighteenth annual meeting of this Society was held at Albany, February 2nd, 3rd and 4th. The attendance was large, and a great amount of practical work was done. Interesting papers were read by Drs. Ely, of Rochester; Drs. Roosa, Loomis, Otis and Goodwillie, of New York; Dr. Powell, of Toronto, and many others. The Society is evidently in a very flourishing condition, and the large number of contributors with a world-wide reputation insures the fact that much benefit will accrue to those taking part in its proceedings.

**DR. HEYWOOD SMITH AND THE STEAD CASE.**—Dr. Smith, the physician who examined a young girl, and gave Mr. Stead a certificate of her virginity, received the following reprimand from the College of Physicians of London:—"It is in the opinion of this College a grave professional and moral offence for any physician to examine physically a young girl, even at the request of a parent, without having first satisfied himself that some decided medical good is likely to accrue to the patient from the examination."

**SANTONIN IN AMENORRHŒA AND DYSMENORRHŒA.**

—J. Cheron (*Revue de Thérapeutique*) writes that the physiological action of santonin on the unstripped muscular fibres and upon the vascular system, renders it especially useful in amenorrhœa and dysmenorrhœa, especially when dependent upon anæmia and chlorosis, as also when the flow has not been properly established. He holds that it acts as a tonic to the system and removes the passive congestion upon which the amenorrhœa or dysmenorrhœa depends. It has no injurious effect upon the stomach. The following will be found a convenient method of prescribing it:

R. Santonini ..... gr. xxx.  
Glycerini..... q. s. M.  
Ft. pil. No. 40.

S.—One or two pills before each meal.

**FUNCTION OF THE SPLEEN.**—M. Phisalix (*Revue Bibliograph des Sciences Médicales*) says that the function of the spleen is the formation of blood corpuscles. Histologically the spleen may be regarded as a modified form of connective tissue, in the cavities of which even from its embryonic period, blood cells are formed. The splenic cells multiply by subdivision, and after becoming free, form red and white blood corpuscles.

**BUCKWHEAT FLOUR IN GLYCOSURIA.**—Dr. A. M. Duncan writes (*Med. Rec.*) that Dr. Alvord, a retired practitioner of Hamber, Ohio, finds relief from glycosuria when he confines himself to a diet of pure buckwheat cakes. The urine becomes normal, or nearly so, in quantity and quality, the pain in the eyes is greatly relieved and the gastric disturbances disappear. When wheaten bread and other starchy foods are resumed as diet, the symptoms reappear, to be relieved by a return to the buckwheat cakes.

**COCAINE IN SEA SICKNESS.**—Dr. Hood mentions the good effects produced by cocaine in sea sickness. His son, who on former voyages suffered excessively, was greatly relieved by the use of the drug, though the passage was a rough one. During the voyage to Calcutta he missed only three regular meals, but had them at these times on deck. The dose was two teaspoonfuls of solution of the hydrochlorate, 1 in 1000. It is best administered before vomiting has commenced, for after

that its power over the affection is diminished. It should be repeated every two or three hours. If cocaine does only one half the good it at present gets credit for, it will be a greater *Mash Allah* than opium, though it appears to be a worse master than even that monster.

**SALICYLATE OF ESERINE IN PHYCTENULAR KERATITIS.**—The following formula is recommended (*Western Medical Reporter*) for use in the treatment of inflammation of the cornea of children.

R. Salicylate Eserine.....gr. ii  
Aqua..... $\frac{1}{2}$  ss. M.

Sig.—One or two drops once a day to be dropped into the eye.

**BRITISH DIPLOMAS.**—The following Canadians have been admitted members of the Royal College of Surgeons, England, at the recent examination. Ed. Furrer, M.D., H. H. Hawley, M.D., J. R. Logan, M.D., N. Allen, M.D., of Trinity University; J. B. Lawson, M.D. (McGill). The L.R.C.P., London, was taken by M. R. Saunders, M.D. (Trinity) and E. E. King, M.B. (Toronto University).

**BORACIC ACID IN DIABETES MELLITUS.**—F. A. Monekton (*Australian Med. Gaz.*) reports he has cured one case of diabetes mellitus with this drug. The patient was not stringently dieted, but was given seven grains of the acid three times a day, and at the end of ten weeks the sugar had all disappeared from the urine, and its specific gravity was reduced from 1025 to 1016. The drug produces no unpleasant effect. He is anxious that all who have an opportunity shall test the value of the drug in this disease.

**LOTION FOR GOUTY JOINTS.**—Dr. Rothe (*Mémorabiiën*) speaks highly of the following solution in an attack of acute gout. Liquor plumbi acetat. 15 parts; spiritus vini, 25 parts; tr. opii ammoniat. 5 parts; aq. font, 300 parts. Having first used frequent cold douches, he applies compresses wet with the above solution and covered with mackintosh. The treatment gives great relief from pain and shortens the attack.

**PURE TEREBCENE IN WINTER COUGH.**—This remedy, prepared by the action of sulphuric acid on oil of turpentine is said to give excellent results

in chronic bronchitis. Dr. Wm. Murrell (*Brit. Med. Jour.*) has employed it in a large number of cases at the Chest Hospital at Westminster, and in private practice, and speaks highly of its efficacy. He recommends it to be taken in doses of five or six drops on sugar every four hours, to be gradually increased to twenty drops. Patients always notice the characteristic odor which it gives the urine.

**EUCALYPTUS AND TURPENTINE IN CROUP.**—In an article in the *Cal. Medical Journal*, Dr. Johnston speaks very highly of the use of eucalyptus and turpentine in the treatment of membranous croup. He sprays the mouth and throat with equal parts of oil of eucalyptus and turpentine every fifteen minutes by means of an atomizer. He was led to the use of these remedies from the fact that they are capable of dissolving India-rubber. He claims to have had good results from their use in the manner above referred to, and also thinks they would be equally serviceable in the local treatment of diphtheria.

**INHALATIONS OF CARBOLIC ACID IN PULMONARY GANGRENE.**—According to M. Paul, says *The Bulletin General de Thérapeutique*, seven cures were effected without untoward symptoms by the inhalation of the vapour of a solution of carbolic acid, one part in seven of water. Eucalyptus in doses of one half drachm of the alcoholates per diem was in addition used internally.

**TREATMENT OF HYPERIDROSIS.**—German army surgeons report favorably of the action of salicylic acid in extreme sweating of the feet. It is applied in the proportion of two parts of pure salicylic acid to one hundred parts of best mutton suet. So simple a remedy will be hailed with delight by those suffering from this most disagreeable disease.

**BROMIDE OF ETHYL IN SECOND STAGE OF LABOR.**—Dr. Montgomery has used this agent for producing anesthesia during the second stage of labor, in a number of cases, and has never seen any unpleasant effects either to the mother or child. The patient is able to co-operate with the physician, never becoming entirely unconscious, while at the same time the pain is reduced to *nil*. It is administered by pouring from a few minims

to a drachm on a cloth and holding it against the face of the patient at the commencement of each pain, removing it in the interval.

**VALERIANATES IN MELANCHOLIA.**—The following is said (Dr. Defoe, *Med. Brief*) to be very effective in the treatment of melancholia in nervous women.

R Zinci Valerianat.

Quiniæ Valerianat.

Ferri Valerianat..... aa gr. xx

Ft. pil. No. xx. Sig.—One three times a day.

**RESORCIN IN EPITHELIOMA.**—Dr. Antonio, of Mazzoro del Vallo Maggio, claims to have cured a case of extensive epithelioma of the face, by the use, twice a day of an ointment consisting of fifteen parts of resorcin to twenty parts of vaseline.

**CURE FOR CORNS.**—It is said that liquor potassæ, applied twice a day, will remove the most stubborn corn in a space of from a few weeks to three or four months.

**CORONER.**—Dr. J. S. Lathern, of Halifax, N.S., has been appointed Coroner for the Co. of Halifax, *vice* Dr. E. Jennings, deceased.

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## Notes, Queries and Replies.

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I should be glad to hear from any of your readers who may have had experience and success in the treatment of Pityriasis Capitis. The patient is a young woman, healthy, functions normal. Disease of two years' standing.

INQUIRER.

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## Books and Pamphlets.

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**DISEASES OF SEDENTARY AND ADVANCED LIFE.**—By J. Milner Fothergill, M.D., London. New York: D. Appleton & Co. Toronto: Willing & Co.

If all American medical republications of foreign works possessed even a moiety of the excellence of the above brilliant treatise, one might almost feel inclined to condone the servility which our boasting cousins evince in their worship of British celebrities. How little short of mortifying it must be to the really patriotic members of the

medical profession in the Great Republic, to run over a catalogue of any of the distinguished publishing houses of New York or Philadelphia, and to see that the works of his own countrymen make so comparatively meagre a show in the entire array. It may truly be said that a British author may look for his largest circulation, not in his own country; and is it not a marvelous fact that this circulation is greatest among a people who *affect* to scorn and deride everything that bears the title or the aspect of British, from the institution of monarchy down (and that is down enough south of the Lakes) to the Bench of Justice? It is no wonder that John Bull has begun to discover so many beautiful traits in his bovine republican cousin nephews. What effect this new inspiration may have on the tenor and tone of general English literature, it would be premature yet to predict. It is by no means unpleasant to any reader of liberal mental tendencies, to observe the indications presented in recent medical English works, of the high appreciation in which American writers are now held on the other side of the water. John has begun the study of national psychology, and he finds it not an indiscreet investment to spice his books with captivating quotations from American writers. Hence has it come to pass that one now tumbles on such names, in recent English medical books as Weir Mitchel, Flint, Da Costa, Wendell Holmes, Bigelow, Draper, Loomis, *et hoc genus nonnullum*.

*Tempora mutantur.* John no longer worships exclusively himself; he bows towards the west. He will be all the better for the change of ritual. Read the following passage from Dr. Fothergill's chapter on the nervous system, in the part in which he is treating of the frailties of old age. "This senility," says Dr. F., "is the bane of the system of presbyters or elders. Where a number of senile personages act in concert, their conduct is such as to demonstrate what has just been said above. The mental moods come out plainly; as is seen in the facility with which a good looking young matron will turn the committee of an institution round her finger, provided that committee consist exclusively of grey or white-headed men. It is exemplified in self-electing oligarchies of senescent persons, as the Royal College of Physicians of London for instance, which is little removed from an intellectual mummy swathed in rags and cerate."

Hurrah for Fothergill! That's the stuff for young America. Hit them again, harder and still harder. That nasty twister! Tar and feather

her; and those old whiteheads! explore their skulls; your shillelah cannot harm them; they are but "intellectual mummies." You are not, are you? indebted to them for your M.D. handle. Does any tale thereby hang? Is your scorn of the concrete order, or is it purely subjective—Pickwickian? No matter which, it is just the thing for young America, and it is not a bad sample of your lively book. It is however but just to say that this fling at the twister and the mummies is the only crabbed passage in the book, and who knows how great had been the provocation? Dr. Fothergill's chapter on "the seminary for young ladies," may very profitably be perused by all parents and teachers. He writes as one who knoweth whereof he treateth. Here is a sample. "In boys' schools the moral advantages of plenty of physical exercise in suppressing certain predilections is fully recognised; but with girls the whole scheme of education is, or rather was, on the devil's side. Much that tends to disaster, to wreck, alike of mind and body, goes on unseen, and therefore uncorrected. This is an imperfect world, doubtless; but would it not be possible to correct some of its imperfections?" Again, "the athlete is rarely a youth of impure thought or vicious practices: this all recognize,—preceptor and physician alike; while the moody youth, solitary and sedentary, is too often steeped in unclean thought." This is plain speaking. Every long experienced and sagacious physician will testify to its truthfulness.

A MANUAL OF HYGIENE AND SANITARY SCIENCE, by a committee of the Ontario Board of Health  
Toronto: Williamson & Co.

The above work will be issued in Toronto in a few weeks, and gives promise of being a useful addition to others of a similar nature now before the public. It is designed to "occupy an intermediate place, between the elementary text books, for the use of children, and more advanced works for students and practitioners of medicine." It deals with such subjects as the composition of the blood, circulation, respiration, ventilation, heating, lighting, functions of the skin, disposal of sewage, nature of infectious diseases, contagion, foods and adulterations, drinks, digestion, alcohol and its abuses, hygiene of the eye and ear, etc. The field covered is quite extensive enough and embraces such a knowledge of the subjects treated of as every intelligent citizen could possess. The work is tolerably free from technical terms, and is therefore well adapted for popular use. We trust that it will be extensively read, and that the many excellent suggestions it contains may be put

into actual practice. If such is the case, we may reasonably expect an improved state of sanitary science and a diminished death-rate in this province.

**MILK ANALYSIS AND INFANT FEEDING**, a practical treatise on the examination of Human and Cow's milk, cream, condensed milk, etc., and directions as to the diet of young infants. By Arthur V. Meigs, M.D. Philadelphia: P. Blakiston, Son & Co.

One would have fancied that the simple law of nature, which points to the milk of the mother as being the most suitable food for her offspring, scarcely required the elaboration of so scientific a treatise as Dr. Meigs has given us. Such however appears not to be the case, and those interested in the feeding of young infants, and who is not, may find in Dr. Meigs' book much that is worth knowing, but whether the preparation he recommends will be found useful in all cases, we have no means at present of ascertaining. Of one thing a somewhat large experience has convinced us, and that is, no one of the many proposed substitutes for the maternal milk can be relied on in all cases. Perhaps the most objectionable of the proposed substitutes are those compounds composed more or less of farinaceous materials. Dr. Meigs certainly does not err in this respect, his substitute being composed of cream, ordinary cow's milk, lime water and solution of milk sugar, a mixture which can scarcely claim either originality or novelty.

**LEONARD'S PHYSICIAN'S POCKET DAY-BOOK**.—Bound in red morocco, with flap, pocket and pencil loop. Price, postpaid, \$1. Published annually by the *Illustrated Medical Journal Co.*, Detroit, Mich.

This popular day-book is now in its ninth year of publication. It accommodates daily charges for fifty patients, besides having cash department, and complete obstetric records. There are also columns for the diagnosis of the case, or for brief record of the treatment adopted. It is bound in flexible covers, weighs about five ounces, and is easily carried in the pocket.

**COMPARATIVE ANATOMY AND PHYSIOLOGY**, by F. Jeffrey Bell, M.A., Prof. Comparative Anatomy at King's College. Illustrated with 229 Engravings. Philadelphia: Lea Bros. & Co., 1885.

This is one of a series of Manuals for students of medicine recently published by Lea Bros. & Co. The work is written in an interesting and attractive style, and will be welcomed by those for whom it is intended.

**WOOD'S POCKET MANUALS.**

**CUTANEOUS MEMORANDA.** By Henry G. Piffard, M.D. Third edition.

**VENEREAL MEMORANDA.** By P. A. Morrow, M.D. William Wood & Co., New York.

The object of these little works is to supply the essentials of their topics in the smallest space possible and in the handiest form. This object is well attained in the specimens before us, which can be recommended as from the pens of competent writers and published in an attractive and eminently convenient form.

**INEBRIISM**—a Pathological and Psychological study by T. L. Wright, M. D., Bellefontaine, Ohio. Price \$1.25.

The above excellent little work consists of an analysis of the inebriate constitution, especially with reference to alcoholic proclivity. Those who may wish to obtain the work can do so by addressing the author as above given.

**MONOGRAPH ON COCA AND ITS ALKALOID COCAINE.** By Wm. R. Warner & Co.: Philadelphia.

The above mentioned Monograph on Coca comprises, in a few words, the most important and necessary information on this subject from all sources. Write to the publishers for a copy.

**A GUIDE TO THE NEW PHARMACOPŒIA (1885)**, comprising an epitome of the changes and an account of the new preparations, their character, uses, doses, and modes of administration, together with a Therapeutical commentary, by Prosser James, M.D., Lecturer on Materia Medica, London Hospital, etc. London: J. & A. Churchill.

**EPITOME OF SKIN DISEASES**; being an abstract of a course of sixteen lectures delivered by Louis A. Duhring, M.D., of the University of Pennsylvania. Philadelphia: J. B. Lippincott & Co.

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### Births, Marriages and Deaths.

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On the 15th of January, Dr. Thos. Hawkins, M.R.C.S., Eng., of Oxley, Ont., aged 78 years.

On the 15th ult., Dr. B. V. Harley, of Carlton, N.S., aged 79 years.

On the 14th ult., M. C. Macleod, M.D., of Economy, N. S. aged 37 years.



# THE CANADA LANCET.

A MONTHLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE.  
CRITICISM AND NEWS.

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## Original Communications.

### SOME MEDICAL AND SURGICAL CASES IN LATE CAMPAIGN—NORTH WEST REBELLION.\*

BY A. J. HORSEY, M. D., OTTAWA, ONT.

Surgeon to the late Midland Battalion.

GENTLEMEN:—It was only a few days ago that I was made aware, that the duties usually performed by the President of this society, were likely to fall upon me, the Vice-President; which prediction unfortunately is verified to-day by the absence of Dr. Cranston, who has found it impossible to be here. I am not going to attempt to address you as he might have thought fit to do, but with your permission, will read a few notes upon some of the medical and surgical cases of the late campaign in the North-West, which came under my notice and care, while serving as surgeon to the late Midland Battalion. But let me first thank you for your great kindness in re-electing me during my absence, to the Vice-Presidency of this Society, a position of honor I feel myself only too incompetent to fill. I do not pretend for my paper scientific exactness, nor can I follow all of the cases about to be cited throughout their entire course, owing to the changeful, restless life of camp; the sick and wounded being as quickly as possible removed to the base hospital at Saskatoon, where they, for a time, were lost sight of.

My first medical duty on my arrival at Kingston, the head-quarters of the Battalion, on the 1st of April, 1885, was a medical inspection of the men: which I was requested not to make too searching, as the Battalion's numerical strength would not admit of much depletion. Fortunately there were very few men found unfit for service, no case in particular deserves sufficient medical importance to be dwelt upon here. Yet there were a variety

of abnormalities and peculiarities in the nude upon which a small volume might be written, which were wholly lost to observation in the clothed state. While here (Kingston), some cases of indisposition, chiefly due to the generosity of parting friends, were brought under my notice: making my first requisition on my medical stores for antacids and contrastimulants, which were found necessary to be continued for a day or two after starting, when whirling westward with all possible speed, over the C. P. R., towards the valley of the great Saskatchewan. When passing Lake Nipissing on the evening of our second day out, a case of delirium *a potu* manifested itself in one of the men of C. Company, and in the following startling manner: He had come into the car set apart for officers: it was said to consult me, and stood in the passage some time without speaking, or otherwise attracting attention, till a crash of glass was heard, and a pair of legs were seen for an instant clearing the car window. He had sprung from where he stood, to the arm of the seat in front of me, and from it took a header through the double plate glass windows of the car, which were closed at the time. While the train, which had been bowling along at about thirty miles an hour, was being stopped and backed up, my assistant-surgeon and hospital-sergeant had the contents of the surgical panniers paraded in review order in the rear car, while I anxiously awaited the recovery of the deserter, speculating on the nature of the injuries such an occurrence might produce. Mental diagrams of the triangles of the neck passed before me, with the positions and relations of the parts about the subclavians marked with red and blue lines, with the best points to ligature. At least expecting an operation of this magnitude, with perhaps a double amputation of both lowers thrown in. But I was doomed to disappointment, for when we had reached the spot where he had struck the snow, and ricocheted two or three times along its surface, he made a final skip into the bush and disappeared. So instead of my taking off his two legs, his two legs took off him.

Passing the gaps my greatest acumen and skill were required in diagnosing between true and false prostration, of which there was a sudden increase since a bottle of genuine Spiritus vini Gallici, was seen to be used in the restoration of one who had

\*Read before the Medico-Chirurgical Society, Ottawa.

fallen out by the way. I assure you the care and distribution of this remedy gave me more trouble than all the others, and I was not sorry when my hospital sergeant with the little keg was outflanked, and the last of it was captured from me near Fort Pitt. At Winnipeg, as we marched through the town, a stout fellow fell out of the ranks from an epileptic seizure, and was left in hospital there. Another was left at Munroe's Harbor with symptoms of pneumonia, and another invalided at Swift Current. From Clark's Crossing two were sent back to Saskatoon Hospital, one because of a scalded leg, the other on account of febrile symptoms. I mention these cases to show how few were left behind, out of a Battalion of nearly 400 men hurriedly mustered with scarcely any selection.

Towards the end of the railway journey, and during our camp at Swift Current, several similar cases of a mild form of ophthalmia arose; in which the conjunctiva of first one eye was inflamed, followed in about a week by the other taking on a similar condition, when the first affected organ gradually recovered its normal condition after another week, and the second a week later, so that the disease ran its course in both eyes in about three weeks. Both the orbital and tarsal mucous membranes conjunctival were much congested, there was little pain or intolerance of light, the disease giving less inconvenience to the possessor of it than appearances would lead one to suppose, many of the patients continuing to do duty throughout the attack. After seeing about a dozen cases, I became quite interested by its migratory character and watched for, and tried to prevent the affection of the second eye, but unsuccessfully. It was treated with astringents, opiates and goggles. I looked upon it as parasitic.

Several cases of rheumatism occurred on board the steamer Northcote, on her trip down the south branch of the Saskatchewan, from Saskatchewan Ferry to Clark's Crossing, a trip which took is twelve days instead of four as we had expected. It is surprising that there was not more sickness, as the men were crowded into the hold of the steamer which was only deep enough to allow of the sitting posture, upon a loose open flooring, under which were several inches of foul bilge water; while they were subjected to occasional urinal irrigations, leaking through the deck from the horses above,

which made its occupation disgusting in the extreme and intolerable.

After a day or two a move was made to the barges, which the Northcote towed on either side laden with fodder. By building walls of bags of oats, bales of hay and hard-tack, around their sides for protection from fire from the banks, and spreading tarpaulin between them at night, a tolerably comfortable pit was made. This tarpaulin was removed during the day, so that the sun and air might purify the pit, and the men be exposed to their healthful influence.

At Batoche a number of gunshot wounds in various parts of the body, came under my observation and care.

Case I.—Private B——, Midland Battalion, a strong, tall, athletic young man, who was the first to fall in the advance on the rifle pits at Batoche, on the 12th of May, 1885. Was struck in the left thigh, on its outer and posterior part, about three inches below the trochanter major; the ball passing inwards and forwards through the limb, emerging therefrom at its inner side, at the fold where thigh and scrotum meet; passing onwards through the scrotum, in which it made a ragged wound at its exit, tearing the tunica vaginalis, and causing hernia of the right testicle, the glandular structure of which was considerably lacerated. The wound in the thigh was probed to find clothing or other foreign matter, after which it was syringed with a weak solution of carbolic acid, and dressed with a weak compress of carbolized gauze dusted with iodoform, held in position by a spica bandage. The edges of the wound of the scrotum were pared and brought together by sutures, after the damaged testicle had been returned to take its chance of recovery. The next day the wounds were dressed and presented nothing unusual in appearance, excepting that the scrotum was considerably swollen and oedematous. On the second day after the injury, he was sent by steamer Northcote up the river Saskatchewan, to the base hospital at Saskatoon, where, according to a published account of the scrotum part of his injury, by Dr. Jas. Bell of Montreal, he passed through many dangerous sequences, including urinary infiltration and sloughing of a great portion of the scrotum—but finally recovered. The right testicle which had been so severely injured made good repair, and was well

covered by integument though diminished in size. He returned home with the column in July, being able to walk by the aid of a stick, complaining only of neuralgic pains of the left lower limb.

Case II.—Lieut. H——, of A. Company, Midland Battalion, of light build and nervous temperament, was, on the 12th May, at about the same place and time as private B——, struck with a rifle ball in the left chest—just beneath the clavicle at the junction of its middle and outer thirds—injuring its under surface and passing backwards and outwards behind the coracoid process, lodged in the head of the humerus, from which it was removed under chloroform, by considerable leverage force after its position had been ascertained, first by probing with a Nelaton's probe and secondly by the finger, which was passed through the wound after enlarging it. Several pieces of clothing were also removed, likewise a splinter of wood about  $\frac{3}{4}$  of an inch in length, being a longitudinal section of a small branch of a tree which had doubtless been carried before the bullet, as he was in a wooded ravine when hit. The wound was syringed with a weak solution of carbolic acid and water, to free it from any remaining foreign matter, and a pledget of carbolized gauze dusted with iodoform applied to the wound, by means of a figure-of-eight bandage, and the arm placed in a sling. This patient was also sent to hospital at Saskatoon, at the same time and in the same manner as the former one. The shock in this case was severe, and his delicate, nervous organization and apprehensiveness of danger, greatly retarded his recovery. While in hospital several spiculae of bone from the under surface of the clavicle came away, and on meeting him in July about two months after the injury, the wound had not quite healed, and roughened bone could still be felt at the lower border of the clavicle. He carried the arm in a sling—the limb was much atrophied, especially about the shoulder when compared with the right, which was hardly a fair comparison. Two cases also recovered of bullet wounds of the fleshy part of the arm about its middle, without injury to bone or vessels, and one of the calf of the leg. In each case the danger was lessened and trouble saved both patient and surgeon, on account of the balls having passed completely through. These required simply dressing with compress and bandage. These cases were also sent off by steamer Northcote to Saskatoon

—the patient with the wound of the calf of the leg suffering considerable surgical fever. They all returned home with the expedition, little damage resulting from their wounds.

Case VI.—Was a very severe gunshot wound of the hand, the ball entering the ulnar side of it at its hypothenar eminence, and passing deeply and obliquely across the palm, in front of the metacarpal bones, emerging on its radial border opposite the first phalanx of the thumb, in which it caused a compound fracture of that bone, a portion of which was removed by the bone forceps. This injury dressed as the others, was followed by more than ordinary shock, and at Saskatoon gave much fear lest amputation should have to be performed, so great was the inflammation and disorganization of the deeper structures; amputation, however, was not found necessary. I have not received any reliable information of the case of late, but believe it to be doing well.

Case VII.—Lieut.-Col. W——, æt. 48, of excitable, nervous temperament, excellent physique and of temperate habits; looking younger than his years would indicate; had enjoyed unexceptional health and vigor throughout the campaign until the morning of the 26th of June, when he complained of feeling "out of sorts," chilliness, and having pains in his legs and thighs.

Two powders containing gr. xx each of quinine were given, one immediately, the other at bedtime when a stimulant was likewise administered. Next morning, Friday, June 25th, he expressed himself as feeling better, but still complained of muscular pains in his lower extremities: was given six powders of gr. v. each, of Pot. iodidi, to be taken at four hour intervals.

*Saturday, June 27th.*—He felt still better, ate his food and went about his duties with little less energy than usual.

*Sunday, June 28th.*—Attended church parade at 10 o'clock a.m., but seemed a little irritable and not in his usual spirits and form, complaining after service of the heat of the sun (which was excessive), and fatigue of standing so long in it; he kept closer than usual to his tent during the remainder of the day, and turned into his blankets early. At 10 o'clock p.m., he was given a stimulant to compose him for sleep, as he was wakeful the night before.

*Monday, June 29th.*—Still feeling unwell, but

did not complain of any part or organ in particular—still going about.

*Tuesday, June 30th.*—Complained of chilliness, stiffness in his legs and muscular pains, spoke of the advisability of going on board the steamer North West to sleep, which I approved of, consequently he went, walking nearly a mile. He was given two pil. cath. co. and a febrifuge mixture, the pills operating freely twice.

*Wednesday, July 1st.*—At 6.30 o'clock a.m. he sent for me, but as I was on parade, Dr. Gravelly saw him instead; and prescribed quinine and Dover powder.

At about 8 o'clock I saw him; he seemed much worse to-day, complained of head-ache, and was slightly delirious, tongue furred, restless, and sleepless; his pupils were normal, pulse 90, temp.  $101\frac{1}{2}$ . Applied cold to his head by means of a coil of rubber tubing.

At 11 a.m. Dr. Pennifather saw him in consultation, when it was agreed to give him gr. xx. am. bromidi every 4 hours, in addition to the febrifuge already given and pil. cath. co. which he received; temperature  $101\frac{1}{2}$ , pulse 84. During the day he was delirious, but could, when spoken to, compose himself and answer questions rationally, but would soon relapse into a stupid state; pupils normal, urine secreted naturally and in good quantity, of a dark color.

*Thursday, July 2nd.*—Morning temp. 102—night  $102\frac{1}{2}$ , tongue brown and dry, passed a restless night. Complains of paroxysmal pains at the top of head, had lateral deviation of eyes towards the right, had a bad day. Was seen by Dr. Pennifather to-day, and constantly by myself.

*Friday, July 3rd.*—Had a restless and delirious night, pulse 90, temp. 102; am. brom. with T. hyoseyami were given, ice to head continued from the first application, also sponging the body freely, takes beef tea and condensed milk in fair quantities; given at bed-time chloral hydratis, gr. xx. repeated three times at hour intervals, giving rest and some sleep. Morning, condition unimproved; Drs. Gravelly, Whiteford, Parry and Ryerson saw him in consultation, and agreed that his symptoms were those of typhoid fever with marked head symptoms, and suggested nothing new as to treatment; throughout the day continued much the same, took some food. In the eve-

ning coma increased, and he appeared to be sinking, skin freely perspiring, alcoholic stimulants given, and icing and sponging the body more vigorously applied, as temperature had risen to  $104^{\circ}$ ; urine drawn off and stimulant injections given, he continually grew worse till 9.15 o'clock Saturday morning, July 4th, when death took place.

REMARKS.—Taking a retrospective view of the case, the symptoms are not those of typical typhoid fever, though experience teaches how protean its course may be. The slowness of the onset of the disease—the malaise, aching limbs, etc., the earlier temperature, appearance of the tongue, and delirium—are suggestive of it. The pulse was slow for typhoid: the disproportion between the pulse and temperature on the one hand, and the delirium, was exceedingly great. The evening temp. was lower than the morning; there was absence of vomiting and pupillary changes, which, with the slow beginning, would go against acute meningitis. There was slight lateral deviation of both eyes towards the right on the seventh day after relief was sought, and about the same time a strange symptom showed itself in exquisite pain in the right great toe—which was not swollen or discolored, but when touched by the bed-clothes or otherwise pressed upon, would cause him to wince even when in a comatose condition—which doubtless was reflex. Whatever the nature of the first cause of the disease, there is little room for doubt that meningitis ensued, which, with its effusion, was the immediate cause of death.

This is strengthened by the family history, which is strongly neurotic.

Had the disease terminated less suddenly, more evidence would have been forthcoming and have put the diagnosis beyond a doubt. But even this is not without its weight in the question.

I feel how very incomplete my narration of the foregoing cases is and regret that it is so, but under the circumstances is unavoidable. I do not know any special lesson that they teach, unless it be that the unexceptional termination of them in recovery, as well as nearly all other wounds of the campaign, would tend to show that the healing of wounds is chiefly due to causes within the body—not to that which is applied externally as dressing—though these are by no means unimportant. Though antiseptics were used in the dressing of

these wounds, it was necessarily in a very imperfect manner—in the open air, within the zareba, amidst clouds of dust, dirt, and animal excretions of all sorts—yet we see the results.

The men were in the most perfect health at the time their wounds were received, having lived in the open air for several weeks before, with plenty of exercise, a simple diet, without stronger stimulant than tea. Looking back over the whole campaign, that which impresses me most is its wonderful healthfulness and extremely low mortality. I doubt not that it would have been as great if the same men had followed their usual occupations at home. And when the reasons for such wonderful salubrity are sought, the greatest factor without doubt will be found to be—not only in the clear, bright, dry atmosphere of the Great Lone Land, which has never been too highly spoken of—but to the fact that we were constantly in it by day and by night, breathing without stint its health-giving properties. From my experience of open-air life and that of dwellings generally and sick rooms in particular, the hygienic importance of pure free air and light do not, I feel, receive their full value—either from the profession or the public—notwithstanding all that has been written and spoken about them

#### NOTES OF A CASE OF DUODENAL PERFORATION.

BY M. DAVISON, M.D., FLORENCE, ONT.

Albert K.—, *et.* 40, farmer, unmarried, of regular and temperate habits, had for years complained of what was termed dyspepsia, and consulted my physicians without permanent benefit. At times he would be free from stomach troubles, again without any known cause his disease would return. Was nearly always able to work, but suffered frequently from pain in the stomach, from three to five hours after meals. He was then obliged to eat something, which generally relieved the distress.

About 6 p.m. December 5th, 1885, was suddenly and violently attacked with intense pain about the region of the stomach. I saw him within half an hour, and found him unable to sit or stand still, and groaning loudly from the intensity of the pain, which now radiated without intermission in every

direction from the stomach. Pulse and temperature normal; no tenderness; pressure well borne; no vomiting. Applied hot fomentations, sinapisms, turpentine, etc., and administered one-quarter grain of morphia every fifteen minutes for two hours, without relief. Continued the morphia in less frequent doses, and gave chloroform by inhalation during the remainder of the night. Suspected perforating ulcer of stomach. December 6th, pain less violent; pulse and temperature normal; tongue slightly coated; no appetite; continued morphia and fomentations. About 7 p.m. had a chill, followed by all the symptoms of extensive peritonitis, pain more general, and very intense. Again administered chloroform, and added *Tr. aconite rad.* in *m ii.* doses. Confined patient to liquid nourishment.

Dec. 7th.—Pulse 120; temperature 103°. All the symptoms of acute general peritonitis. Gave morphia in large and frequent doses. Dr. Duncan of Thamesville called in consultation, who concurred in diagnosis of perforation, and in treatment, which was continued.

Dec. 8th.—Pulse irregular and rapid; temperature 100°; delirium; cold perspiration; extreme prostration; condition of partial collapse; stimulants by skin and stomach *ad lib.*

Dec. 9th.—Collapse not quite so great; pulse weak, irregular and fluttering; faintness, perspiration, temperature 100°. Gave morphia, and *Tr. digitalis*, with milk and whiskey *ad lib.*

Dec. 10.—Slight improvement in heart's action; tympanitis abating; pain not so severe; took more liquid nourishment, with stimulants; slight jaundice beginning to appear in conjunctiva and skin.

Dec. 12th.—Gradual improvement in all the symptoms; tympanitis nearly gone; some fluctuation from serum; bowels moved for the first time since attack. First motions feculent, followed by very large quantities of dark blood of tarry consistence and color.

Dec. 15th.—Still slowly improving; dark blood continued passing frequently till to-day, when fresh blood appeared in moderate quantity; troubled with hiccough; appetite improving; dietary confined as far as possible to liquids, although some solid food was given by the friends at times. Continued morphia and digitalis, in less frequent doses; kidneys acting well; urine healthy; moderate fluctuation.

Dec. 20th.—Temperature 99°; pulse 80 to 100; tongue clean; tenderness of abdomen nearly gone; gaining strength; takes plenty of liquid nourishment. Fluctuation not so apparent; some hardness felt in abdomen on pressure, especially marked about the region of bladder; passed catheter, hardness remains.

Dec. 25th.—Continued to improve till this evening. Had a slight chill; pulse and temperature elevated; more pain; depression. Symptoms continued to grow gradually worse till 1 a.m. December 31st, when he died.

POST MORTEM—Seventeen hours after death. Assisted by Drs. Campbell of Florence, Pickard of Thamesville, and Mr. Charters, a medical student. Peritoneum dark-red, thickened, with many adhesions. Omentum dark-red, attached to abdominal walls, intestines, etc., in many places. Intestines bound together by numerous bands and adhesions. Briefly we found all the evidences of past, universal peritonitis. Small quantity of serum mixed with pus in abdomen, and large quantities of pus scattered throughout the interstices of the intestines. Stomach and duodenum empty. No ulceration of stomach proper, so far as could be seen by a moderately careful examination. Duodenum perforated on its right anterior aspect about one inch below the pyloric orifice; opening about the size of a ten cent piece, first finger would slip through quite easily. Walls of duodenum thinned for an inch or more surrounding perforation, and darkened by pigmentary deposit. About three inches of that portion of the liver adjacent to duodenum was of a dark red color and softened by inflammation, rest of liver healthy. The other abdominal viscera were apparently in a healthy condition. So far as I am aware, perforation of the duodenum is not a common occurrence. If it were, this case would be remarkable from the early subsidence of the peritonitis, the gradual but marked improvement in all the symptoms, for nearly three weeks, and the length of time which elapsed before death. Dr. Reeves of London, Eng., says "this is a very rare lesion, only one case has fallen under my own observation, and not more than nineteen have been recorded." In sixteen of these cases, in which he has recorded the time life was prolonged, only two exceeded twenty-six hours, one patient survived forty-four hours, and the other ninety hours. Dr. Habershon, in his article on the duo-

denum, gives but one instance of perforation from primary disease.

That the ulcer had been chronic cannot be doubted, both from the history of the case, and from the marked pigmentary deposit found in the thin and ulcerated portion of the duodenum in the vicinity of the circular opening.

This patient had for more than ten years complained more or less of pain or distress some hours after meals, which was generally alleviated by taking food. This would seem to indicate that when the contents of the stomach passed into the duodenum it caused uneasiness or distress. Why food taken into the stomach relieved it, is not so clear. He had often been relieved by taking a teaspoonful of sodæ bicarb., and possibly the excess of acid in the gastric juice may have passed into the duodenum and irritated the ulcer, and food which absorbed, or soda which neutralized it, would thus give relief. The ulcer being in the first portion of the duodenum would naturally react on the stomach, as that portion of the duodenum is supplied by branches of the same nerves and bloodvessels as the stomach. This would account for the various dyspeptic symptoms so long complained of. No blood was vomited, nor was there any great irritability of the stomach at any time after the perforation. After the subsidence of the peritonitis, hiccup was very troublesome for a few days, which was not allayed by any of the remedies administered, although two other medical men of experience were called in for the purpose. These gentlemen were strongly of opinion that there could have been no perforation, on account of the improved condition of the patient, and I began to hope that the perforation had been very minute, and was closed with lymph, and to entertain some hope of his ultimate recovery.

The early subsidence of the peritonitis was in all probability chiefly owing to the excessive hemorrhage from either the pyloric branch of the gastric or the pancreatico-duodenalis artery—probably the latter, which would be below the opening, and consequently the blood would be carried downward into the bowels, as very little blood was found in the abdominal cavity. The collapse on the third and fourth days was evidently due to loss of blood, as his recovery from it could be accounted for in no other way.

Now that the abdominal cavity, during life, is

not the *terra incognita* which it once was, it naturally occurs to us, from this and similar cases, that surgical interference might afford a probable prospect of saving life, were it resorted to prior to inflammation, and even a possible prospect after. Were the abdomen opened, foreign matter removed, and the perforation closed by suture, there would certainly be a hope of recovery, and without some such operation there can be none. Again, were we able from more careful attention to the symptoms, to diagnose ulceration of the duodenum, there is every probability that it might be remedied by treatment similar to that prescribed for ulceration of the stomach, especially by long continued and careful regulation of the diet. We know that ulceration of the stomach is quite common, and is often cured before perforation, even after repeated attacks of excessive hemorrhage have occurred. It is more than probable that ulceration of the duodenum occurs more frequently than is suspected or diagnosed, and gets well spontaneously, or is benefited by the treatment prescribed for that nosological blunder, dyspepsia, which, like charity, hides a multitude of sins.

#### PUERPERAL ECLAMPSIA TREATED BY PILOCARPINE, AND SUBSEQUENTLY BY MORPHINE AND POTAS. BROMID. HYPODERMICALLY.\*

BY J. CAMPBELL, M.D., C.M., L.R.C.P., EDIN.,  
SEAFORTH, ONT.

Was called at 1 o'clock a.m., on November 10th, 1875, to attend a young married woman in her first confinement, who was taken with severe pains, but not supposed to be those of labor, unless it was a miscarriage, as she had not come to her full time. Reached the house at 2 a.m., and recognized the pains as those of labor.

Made an examination, and found the head presenting and the labor well advanced. The case progressed rapidly without any bad symptoms, and shortly before 6 a.m. she was safely delivered of a female child, evidently somewhat before the right time. After the delivery of the child the placenta was found in the vagina, and of course was delivered without any trouble. Waited a full hour and no bad symptoms supervening, left for home.

We might say that there were no bad symptoms, such as swelling of the legs, œdema of the eyelids, dimness of vision, or anything to lead me to suppose that there would be any subsequent trouble.

When we reached Seaforth, found a telegram waiting, asking me to go back immediately, which I did. Found she had taken a severe convulsion at 8 o'clock. Reached the house at 9 to find her in another, which was very violent, and of the epileptiform variety. After this fit she remained in a comatose state. Injected gr.  $\frac{1}{4}$  of pilocarpine under the skin; gave an enema which, however, came away; put a drop of ol. croton. in ol. ricini on the tongue, but she could not swallow; put cold cloths to the head, mustard to the feet, a hot linseed meal poultice to the back; admitted plenty of fresh air into the room, kept all out but the nurse, and sat and watched the case. Repeated the injections of pilocarpine at intervals of half an hour, until diaphoresis and salivation were produced. The temperature continued about 102°; respiration 40; tested the urine and found it nearly solid with albumen. At 11.30 she took another severe convulsion, but not quite as prolonged as the one at 8 o'clock. Gave chloroform to mitigate the attack, for though we had faith in the pilocarpine, we resolved to aid it by auxiliary remedies. The pupils were at first dilated, but contracted under the influence of the pilocarpine. The temperature fell under the influence of the drug. She took the third convulsion at 11.30, when we used the anæsthetic as before. The friends asked me the question, "Is there any danger?" I replied, "There is always danger in such cases." They proposed that Dr. Smith, of Seaforth, be called in, to which I assented, going on with the pilocarpine treatment in the meantime, and testing the urine at intervals as before, which I was enabled to do particularly, having one of Wyeth's Cabinets along with me.

Our patient took the fourth convulsion at 2 p.m., which was hardly as pronounced as the previous one. Dr. Smith arrived in time to see her take the fifth, which was at 5.30. The Dr. approved of the treatment, and we both resolved to stick to our patient and see her through her trouble. We tested the urine and found that the albumen was gradually but surely diminishing. At 4 p.m. the pulse was still 130, and the temp. 101°; the pupils being now considerably dilated, and the patient

\*Read before the Huron Med. Association, Jan. 12th, '86.



quite comatose. Later on in the evening she could be aroused to consciousness, and at one time gave a hopeful sign by opening her eyes, speaking to and recognizing her friends. Examination of the urine at this time showed that *two-thirds* of it was albumen. We may state that she vomited freely several times during the afternoon. In consultation we discussed venesection, but the pulse remaining small and rapid, we decided against it. Gave an enema of  $\mathfrak{z}$ i. chloral hydrat. in solution, which was immediately rejected. Sweating and salivation still continued profusely and was kept up by repeated doses of the pilocarpine, as we both looked upon this drug as our sheet anchor, and the termination of the case proves that we were not disappointed, as to this remedy no doubt the patient owes her life. The salivation and diaphoresis were prompt and continuous, and began in each case in about fifteen minutes after each dose, and no doubt was aided by the hot applications which have already been mentioned. There were not in this case any of those alarming symptoms which are said to arise from the use of pilocarpine, such as threatened suffocation from the amount of bronchial secretion, etc.

At 6 p.m. the alarming symptoms having all passed away, the pupils being dilated, and the albumen having diminished greatly, we administered hypodermically gr.  $\frac{1}{4}$  of morph. sulph. and subsequently gave  $\mathfrak{z}$ i. of potas. bromid. in  $\mathfrak{z}$ ij. of water which was retained. Shortly after this she passed into a quiet sleep lasting over an hour, during which time she perspired profusely. Between 8 and 9 o'clock we made another examination of the urine and found that albumen was scarcely *one-half* of what it had been at the previous examination. The respirations at 9 p.m. were reduced to 24, and the pulse to 100 per minute. We looked upon all the symptoms as most hopeful, and as there were no indications of returning convulsions we left her for the night.

The sequel will show that our most sanguine expectations in this respect were fully realized. Visited her next day, and put her upon a diuretic mixture; found the albumen very much diminished, and all the symptoms very much improved. Saw her again on the 12th, and likewise on the 13th, when I discontinued my visits, as the albumen had almost entirely disappeared and the patient was doing well in every respect. The

milk was secreted at the usual time, and both mother and child made an excellent recovery.

REMARKS.—I. We believe the principal, if not the only cause of the albuminuria in this case was tight lacing, which was resorted to for obvious reasons. The gravid uterus would be pressed back upon the renal veins, abdominal aorta, or even up above on the ureters themselves, with the result stated.

II. The foregoing being the predisposing cause, we believe mental emotion to be the exciting cause, as she was shocked at the idea of having a child before she had been married the usual orthodox time, and when she was pronounced to be in labor, she never spoke nor uttered a cry during all the time she was in pain, nor smiled when a child was presented to her.

## Correspondence.

To the Editor of the CANADA LANCET

SIR,—In your able and exhaustive article on the Treatment of Pneumonia, in the February number of the LANCET, I notice what must certainly be an accidental omission. It is this, that in the absence of venesection in any case, it not being advisable, depletion of the blood must be brought about by *free purgation*. In order to be of vital benefit it must be free, and as early in the disease as possible, at least within the first forty-eight hours; in order to prevent that engorgement of the lung, from which mischief arises to the lung, a remedy must be used which is sure, and especially in the country, where we can often not see our patients more than once in the twenty-four or even forty-eight hours. There must be no chance work, as otherwise much time is lost and lives lost. Not only on this account must the remedy be sure and powerful, but also from the fact, which all of us know by experience, that patients during the initial stage are very costive and mild purgatives have no effect. If this be essential, what should we use? My plan lately tried on adults, and from which no evil results have thus far followed, is to give one or even two drops or croton oil in  $\mathfrak{z}$ i of castor oil, repeated if needed in three or four hours: one dose however often produces from three to five watery stools, and much improvement in patient's condition as to pain, headache, etc., follows.

It is through paying proper attention to such, what

may seem trivial matters in treatment, that patients often have a better chance in one than another physician's hands, and here we have what pathology would certainly encourage as safe, and practice will substantiate equally as well. At least custom favors us to adopt remedies in this as well as other diseases which, to say the least, are doubtful in effect, yet still adopted because authority dictates so. For example how many of us have tried quinine in large doses to reduce the temperature, only to fail, but try again in our next case because we have no other resource or better remedy.

As the object of your article is no doubt to arouse interest and even discussion, from our common source of practical experience, you will pardon my sending you these thoughts.

Yours truly,

G. SCHMIDT, M.B.

New Hamburg, Feb. 24th, 1886.

To the Editor of the CANADA LANCET.

SIR,—In your issue for March, in an article entitled "American Health Association," you say—  
"We have reason to know that the present Central Board will send delegates, and also that the Provinces of New Brunswick, Nova Scotia, and Prince Edward Island will send their fair share." Now, as the subject has never been brought before the medical profession of Nova Scotia, may I be permitted to enquire what reason you have for knowing that the meeting will be represented by delegates from this Province?

Yours, etc.,

Halifax, N.S., March 9, 1886.

M.D.

[In reply to the above we would say that Dr. Theodore Covernton, chief of the staff of Inspectors for Ontario, visited the Maritime Provinces in January last, and met as many of the medical men in St. John, Halifax, and other places as it was convenient for him to do. He brought the matter referred to under their notice and urged the advisability of sending delegates to the American Public Health Association, to be held in Toronto in October next, and from expressions of gentlemen present at these meetings, and also from members of the respective governments, he had reason to hope that delegates would be appointed either by the respective Governments or by medical societies.—ED. LANCET].

## Reports of Societies.

### MONTREAL MEDICO-CHIRURGICAL SOCIETY.

The regular meeting of this society was held on the evening of the 19th February, Dr. Roddick in the chair. Dr. Ross shewed an interesting specimen of stricture of the œsophagus, due to malignant disease. Though the stenosis was most marked, he upon two occasions passed the largest sized œsophageal bougie ( $\frac{3}{4}$  in.) down the whole length with difficulty. P. M.—A large abscess of the left lung was found, and into this cavity the bougie had doubtless entered. The constriction of œsophagus barely allowed a No. 1 bougie to pass. A remarkable feature was the absence of any aperture larger than a crowquill, leading to the lung cavity.

Dr. Johnston exhibited a rare specimen of malignant disease of the spleen in a dog; weight, 4lbs.

Dr. Gordon exhibited a dermoid cyst of the ovary, containing hair, bone, teeth, and contents which solidified when exposed to the air; also the ovaries removed for a bleeding myoma. Both patients were doing well.

Dr. Roddick shewed a calculus, weight, two oz., two drachms, removed successfully by the lateral operation.

Dr. Trenholme exhibited a uterine fibroid, removed with uterus on 8th inst.; the growth is of a trefoil appearance, the larger growth being on the right side of the uterus. Uterus also shared in the growth, its depth being 6 in. The whole mass (5lbs.) was firmly fixed in cavity of pelvis, and raised up out of it with much difficulty. Uterus was divided about an inch from external os, and the tumor on right side sliced off at its lower part in doing so. There was a good deal of oozing, and many ligatures were applied, and finally the edges of incision brought together with a running suture. Had proposed removing ovaries and tubes, but this was found impracticable. Patient showed lack of vitality, and nearly died on the table. After operation she came out of the ether well, but did not rally satisfactorily, although 5 hours after the operation she said she felt better, no pain, was very tired—heart's action very feeble—7 hours after operation she died from shock. This patient had suffered for the last 16 years, but

it was only for the past 5 years she was aware of the growth. Suffered most at menstrual period, and these sufferings constantly got worse. About 4 weeks ago she nearly died. This last illness determined her to seek relief, and she was sent to Dr. Trenholme. Dr. Trenholme also said that with reference to the ovaries and tubes removed from two patients, and exhibited to the Society at its last meeting, and about the history of which further information was sought, that both of these cases were recovering, and that in one case where convulsions occurred at each menstrual period, and replaced the flow, he had found upon further enquiry that the fits were epileptic. The patient would bite her tongue, and the only way to prevent this was to place some hard substance between her teeth. The attacks were preceded by an aura—a numbness and tingling in left side, leg and arm, which, when it reached the head was followed by the convulsions. This patient though she has several times felt premonitions of the fit, as yet has not had a convulsion. Hereafter I hope to give a further report concerning this case.

Dr. Fenwick gave a short paper on 8 cases of cancer of the rectum. In the greater number of these cases the disease was chiefly in the anterior wall. Dr. Fenwick said that excision of the gut had been of benefit in all the cases, and in some had given years of relief.

### HAMILTON MEDICAL AND SURGICAL SOCIETY.

The regular meeting of this Society was held on the 20th of February.

After routine business, Drs. McCargow and F. E. Wolverton were appointed pathologists to the City Hospital.

Dr. H. S. Griffin showed a case of a young man from whose knee he had removed a loose cartilage. Had felt pain in right knee from childhood. Had never had rheumatism or sickness of any kind.

The body was freely movable and difficult to retain in any one position: about the size of a hickory nut. On December 20th the cartilage was removed by making a straight incision on inner side of knee; under the spray. No difficulty was experienced. The wound was dressed antiseptically, and dressing not removed until the seventh day, when the stitches were taken out.

The wound healed by first intention. No bad symptoms occurred. Use of knee is perfect and painless. The body removed was of a rounded outline about  $\frac{3}{4}$  of an inch, in diameter, and calcareous on one side.

Dr. McCargow presented a case of contracted lung. The case was one of peculiar interest, on account of the complete contraction of the left lung. The patient, aged 74, was brought to the city hospital and placed under the care of Dr. H. S. Griffin. There was complete dullness over the left side of the chest. The patient was in a dying condition. His previous history could not be obtained. The post-mortem notes taken by Dr. F. E. Wolverton: Body well nourished; slight œdema of upper and lower extremities; *rigor mortis* well marked. On making the usual incision a considerable amount (about four pints) of dark bloody fluid escaped, principally from the left pleural cavity. Lung contracted to a mere band, and very thick and tenacious, the fluid filling the remainder of the cavity on the left side of the chest; weight of lung, 9 $\frac{3}{4}$  ounces; sank in water. Pleural surface studded with hard, white bodies; costal pleura thickened and studded with tubercular deposits in upper part, in a purulent state. Right lung was adherent to a considerable extent, and there was some fluid in the pleural cavity—about 1 $\frac{1}{2}$  pints. Lung crepitant. Weight 29 ounces. Respiration was carried on entirely by the right lung. Weight of heart 10 $\frac{1}{4}$  ounces; aortic valves competent, 3 ounces of fluid in pericardium, of a similar nature to the fluid in the pleura. Liver weighed 3 pounds 5 $\frac{3}{4}$  ounces, nutmeg appearance and very soft. Kidneys: Right had three large cysts on surface—pelvis fatty; left had a large cyst at lower end and several in the substance—pelvis also fatty.

Dr. McCargow presented a case which came into the Hamilton Hospital, December 20th, with acute periostitis of the right humerus.

*History.*—Complains of pain and tenderness on inner side of right arm. January 4th, says his right wrist pains him when moved; arm red and very painful from elbow to shoulder. He felt a pain in the spine of the scapula last summer; arm first became enlarged in October last, when he felt a constant burning pain in his arm, attended with much swelling. About three weeks ago his arm was lanced, when a large quantity of pus escaped.

On admission to the hospital a small hole was seen about the middle of the humerus. Pressure on shoulder and under part of arm caused the discharge of a considerably quantity of clear serous fluid. On the evening of the 1st of January a second sinus opened about half an inch above the first, which discharged a quantity of pus mixed with serous fluid. On probing, rough bone was felt at upper end of humerus.

### Selected Articles.

#### THE TREATMENT OF CHRONIC RHEUMATISM.

Dr. J. C. Peters, in a paper read before the N. Y. Academy of Medicine, and published in *Med. Record*, said: Almost all rheumatisms are connected with an excessively acid condition of many of the secretions and excretions, including the saliva, perspiration, and urine; even the chyme and blood are less alkaline than they should be. Next is the excessive preponderance of fibrin in the blood, and the great and early destruction of red blood-globules.

Alkalies form the natural basis of the treatment of almost all rheumatisms, and the first question which arises is whether the potash or soda salts shall be used, or both. As the phosphates and potash salts naturally predominate in the red corpuscles and in the formed tissues, while the chlorides and soda salts are most abundant in the serum and plasma, and in all the infiltrating fluids of all the organs of the body, both potash and soda may have to be used; and they will so aid and compensate each other that neither will have to be given in excess. In chronic rheumatisms Dr. Peters preferred the milder and more tonic soda and potash salts, such as the phosphate of soda, etc. This is a good and mild laxative when purgatives are required; it also lessens the acidity of the mouth, stomach and bowels, which is apt to be present, renders the contents of the thoracic duct and the blood more alkaline, and makes the urine and perspiration alkaline. It also lessens the quantity of fibrin in the blood. It is a cooling and slightly antipyretic remedy, and may be used in strong or saturated solution as a local application to chronically swelled joints. In chronic arthritic rheumatism Charcot prefers the carbonate of soda, of which he gives from seven to ten drachms a day, even to old and feeble women, and says he has never seen anæmia or any dissolution of the blood caused by it; on the contrary, his patients even grew stouter and stronger, possibly from the better digestion of sugar, starch and fat which is caused by this and other alkalies. It

also aids in the destruction of an excess of fibrin in the blood, and helps the liver in its great work of destroying fibrin.

Phosphate of soda is a gentle and pleasant remedy, which may be given in about the way that citrate of potash and Rochelle salts are usually given; the latter in half or one ounce doses when laxation is required, and either in one or two drachm doses when their alkaline effects are more desired. It neutralizes all acids, even that which is abnormally present low down in the large bowels, and moderates the excessive acidity of the normal acid phosphate of soda in the urine, and then helps to keep the uric acid and the other urates in solution.

But potash is the natural alkali of the red blood-globules, of the muscles, fibres, and all other formed and solid tissues; and citrate of potash, and even Rochelle salts, which is a tartrate of soda and potash, may reach not only the serum of the blood, but the blood-globules and the parenchymatous structures, when rheumatism is firmly lodged in the latter.

Benzoate of soda is another non-depressing soda salt, although it is somewhat antipyretic when given in large doses. It is a solvent of uric acid, increases the elimination of urates in rheumatic lithiasis, and seems not only to convert uric acid into hippuric, but also to liberate a portion of the products of disassimilation in the form of soluble hippuric acid instead of insoluble uric. In delicate and sensitive patients benzoate of soda may be given with aromatic spirits of ammonia, thus:

R—Sodii benzoatis, . . . . .	3 vj.
Spts. ammon. aromat., . . . . .	3 vj.
Spts. myristicæ, . . . . .	5 vi.
Spts. chloroformi, . . . . .	5 ij.
Spts. gaultheria, . . . . .	ad. 3 vj.—M.
Sig.—5 j. to 5 ij. in water.	

The hippurate of soda has been suggested lately in doses of five to thirty grains. It tends to produce soluble urates. A favorite prescription with Granville is:

R—Sodii hippuratis, . . . . .	3 ij.
Glycerini, . . . . .	5 vj.
Aq. cinnamomi, . . . . .	ad. 3 vj.
Sig.—5 ij. to 5 viii. three times a day.	

The tauro-cholate of soda also holds uric acid in solution, and is said to render the stools characteristically rich in bile without causing purging. The usual dose is three to six grains, and it is said to be most useful in obese rheumatic patients, in whom the excess of fat slowly melts away. It is doubtful whether it is more useful than purified ox-gall.

The salicylate of soda is only useful in the acute aggravations of chronic rheumatism. It does not destroy the rheumatic element in the blood.

Valerianate of soda is declared by Granville to be very useful in weak and very sensitive patients. He even thinks its therapeutic value is decidedly greater than that of most of the other salts of soda. It relieves the nervous trouble and hyperaesthesia of rheumatism and gout quite effectively, and he cannot help thinking that it also promotes the activity of the absorbents, thus tending to remove congestion, exudation, and even thickening and hardening about rheumatic joints. Usual dose, one to five grains.

It may be assumed that all the good that can be got out of soda will be obtained by these preparations. Charcot always gives quinine, also, when he uses soda or potash in large and long continued doses. Others prefer salicine as an anti-rheumatic tonic. Both prevent the excessive formation of uric acid. But the tartrate of potash and iron is the best tonic against the anaemia and debility of chronic rheumatism. It is pleasanter and better than the muriate tincture.

But, as before said, the soda salts only reach the liver and pancreas, the intestinal juices, the chyle and serum of the blood. They do not penetrate into the interior of the red blood-globules, nor into the parenchyma of the muscles and fibrous tissues, which the potash salts do. The acetate of potash, quickly supported by iron, is a most valuable remedy in subacute rheumatism, and especially in those forms which are liable to frequent acute exacerbations.

But citrate of potash is a much more pleasant and less depressing remedy in very chronic cases.

There are, pathologically, two great varieties of chronic rheumatic joint disease: 1, the fibrous; 2, the dendritic. In the fibrous form the tendency of all the exudations is fibrogenous. The inflammatory products or thickenings, instead of remaining in the soft and gelatinous stage of fungoid granulation, become firm and tough. The new cells are converted into fibres, and these harden and contract; even the inner surface of the synovial membrane is made hard. The normal dendritic growths of the villi are conspicuously absent, and in place of them are thick folds of fibrous tissue. The synovial membrane itself is infiltrated with fibrinous substance, composed entirely of fibre-cells, both fusiform and oval; only a few round cells are to be seen.

The favorite remedy for this state is the muriate of ammonia, administered as freely as iodide of potash is often given. If fears are entertained that it will prove too debilitating, it may be aided by aromatic spirits of ammonia, or by quinine, or Huxam's tincture of bark; although Granville prefers the tincture of serpentaria, which he thinks has a specific effect. The muriate tincture of iron should not be forgotten.

Muriate of ammonia is a solvent and liqueficient remedy which tends to render all the secre-

tions more abundant, while at the same time it reduces the plasticity of the blood and destroys fibrin.

It acts upon the kidneys, and if long continued will cause emaciation, commencing first with absorption of fats and then of soft fibrin. It is used both internally and locally against fibrous thickening of the ligaments and tendons about rheumatic joints. Some go so far as to think it almost specific against all cirrhotic affections of the connective tissues. In chronic rheumatic synovitis it is said to break down all the exudations into a thin mucoid substance, which is finally absorbed. It also has a powerful effect on the formation of urea; it is not only converted into urea, but helps to break down uric acid into urea, and aids in the excretion of both. It is also supposed to be really useful in so-called rheumatic neuralgias, when the fibrous sheaths of the nerves are involved. The dose is from five to fifteen grains, up to one hundred and fifty grains a day.

Its great rival is corrosive sublimate, which may be given in doses of one-twenty-fourth to one-sixteenth or more of a grain, in Huxham's tincture of bark, or in the tincture of serpentaria.

The next great variety of chronic rheumatic arthritis, or synovitis, is the dendritic, in which the folds or fringes of the synovial membrane are greatly developed, so as to nearly resemble papillomata. For this sabina has been suggested, especially when it occurs in females at the menopause, or where there is decided uterine derangement. Sabina once had a great repute, which was not undeserved, in chronic rheumatism and gout, for which it was employed both internally and locally to the affected joints.

Pulsatilla is a remedy which is supposed to act specifically upon almost all the mucous and synovial membranes, especially those of the small joints, and has a well-assured reputation in chronic rheumatism. It is most useful in subacute and chronic arthritic rheumatism when there is little or no fever; also in what is called rheumatic gout in females, with catarrhal and rheumatic disorders of menstruation.

But next to carbonate of soda, Charcot prefers iodine to the muriate of ammonia and sabina; not iodide of potash, but tincture of iodine, in doses steadily increased from eight to ten drops in twenty-four hours, up to thirty to sixty drops. He gives it during meals in water slightly sweetened, or in a glass of Spanish wine, which he says is better. He continues it for several weeks, or even months, and says it never gives rise to symptoms of iodine poisoning. Probably its effects are largely counteracted by the starch in the food. Granville also thinks iodine the most potent and suitable medicine to decompose urates in the blood, and says it relieves chronic rheumatic pains so promptly that he has rarely to use anodynes.

But he always gives it combined with muriate of ammonia and chlorate of potash, thus :

R—Ammonii chloridi, . . . . . 3 ss.  
 Potassæ chloratis, . . . . . 5 ij.  
 Tinct. iodii, . . . . . 5 ij.  
 Glycerini, . . . . . 5 ss.  
 Aq., . . . . . ad. 5 xij.—M.

Sig.—From a tea to a tablespoonful two or three times a day.

The taste of this mixture is more disagreeable than that of the tincture of iodine. One of the best prescriptions is that of Dr. Buckler, viz. :

R—Iod. potass., . . . . . grs. ij.  
 Iodid ferri, . . . . . gr. j.  
 Iodine, . . . . . gr. ʒi.  
 Ext. conii mac., . . . . . gr. j.

Sig.—Make one pill, to be taken three times a day.

These pills are easily taken, and are said to be particularly efficacious in chronic articular rheumatism, even where there is an anæmic, scrofulous, or syphilitic taint. The so-called nodosity of the joints has been successfully treated with iodine.

Arsenic is the great rival of corrosive sublimate, iodine, and muriate of ammonia in chronic rheumatism of the larger joints. Occasionally it produces marked amelioration, but it often fails, and is said to be useless in the most inveterate cases. It generally aggravates at first.

Phosphorus is a more reliable remedy in arthritis deformans, and phosphate of ammonia forms more soluble salts with uric acid than any preparation of soda or lime. Uric acid and the urates disappear rapidly from the urine made after its use, and pains and swellings of the joints are relieved as rapidly as from any preparation of soda and potash. It is fully equal to the other alkalis, and preferable to most of them in delicate and feeble subjects. It maintains a highly alkaline condition of the blood, has a distinctly alkaline reaction itself, and renders the urine alkaline.

## THERAPEUTICS OF HIGH TEMPERATURE.

Dr. Watson, in a clinical lecture published in the *Arch. Pediatrics*, says, substantially : While I do not intend to speak of the causes of high temperature to-day (as we daily go over that ground with each case appearing before us), yet you must remember that in some cases your treatment must be directed toward the removal of any existing exciting cause. Thus, you may have a high fever from an acute attack of indigestion, and obviously you should relieve that. This, then, leads me to say that it is good practice in nearly all your cases with high fever to precede your regular febrile treatment by clearing out the gas-

tro-intestinal canal. You can do this with castor oil, rhubarb, frequently combined with soda, or with calomel and soda, as in this prescription :

R Hydrarg. chl. mitis, . . . grs. j. to ij.  
 Sodii bicarbonatis, . . . grs. ij. to xv.

Followed by a seidlitz powder in milk, in three or four hours.

The most available, and, at the same time, valuable internal remedies are ac nite, quinine, and antipyrine.

1. *Aconite*. The best preparation of this drug to use is the tincture of the root, and is given in plain water, or it may be combined with other febrifuges. On account of its comparative tastelessness, it is readily taken by young children, and as I have told you about all tasteless and non-irritant medicines, it is best to give it in small and frequently repeated doses.

On account of its frequent prostrating effects, you should see the child taking it every two or three hours. When this is impossible, I have found the following plan to answer very well, viz., for a child under two years of age, I prescribe one-twelfth of a drop every fifteen minutes for the first hour, and then every half hour for two hours, and subsequently every hour, until my next visit. You will, however, get better results from it if you give it every ten or fifteen minutes, and see the child at least every second hour. A precaution that I always give the mother is to stop giving it when the child begins to perspire. This is usually, though not always, a reliable guide.

The indications for its use are a hot, dry skin, full and frequent pulse, and a temperature over 102° F. Hence, its value is most marked in the pneumonias, in the eruptive and desquamative stages of the exanthemata, and in the acute inflammations of the serous membranes.

While you will find this drug one of the most valuable anti-febrifuges, yet it will fail in some cases, and if you have produced a marked effect on the quality and frequency of the pulse, without any fall in the temperature, then you must abandon its use for another remedy which I will shortly tell you about. In some cases you will get excellent results with the following combination, viz. :  
 R—Tr. aconiti rad. gtt. ij : sp. æth. nitrosi, 5 ij :  
 glycerinæ, 5 ij : liq. ammon. acet. q. s. ad. 5 ij. M.  
 S. 5 ss. q. h.

If the child has more or less delirium, it will be well to add five or ten drops of paregoric to each dose as given. As I have frequently told you, it is always better to prescribe your preparation of opium separately, so that you can increase or diminish its quantity as desired.

2. *Quinine*.—For those of you who live in districts where malaria is either the primary or a complicating factor in nearly all diseases, quinine will be your sheet-anchor.

In nearly all cases it will be advisable to pre-

cede the use of quinine by a mouth cathartic. One of the best ways to give quinine by the mouth to young children is in the form of a powder. When given this way have the quinine dispensed in one-grain powders, and add one or more, as desired, to a teaspoonful of milk, coffee, chocolate or liquorice, at the time of its administration.

Sometimes I add ten or fifteen drops of the fluid extract of liquorice-root to a teaspoonful of milk, in which the bitter taste of the quinine is very well disguised. Again, you will find cases which will take the quinine in powder alone.

The Elix. Taraxaci Comp. is also a very good vehicle for the administration of quinine, and there are also several other compounds upon the market for a similar object, but I don't think you will require them, especially with children. As with adults, so with children, the most reliable effects will be obtained from the use of an acid solution of the quinine, but its very bitter taste would be objectionable in most cases.

I have frequently used quinine in suppositories with very satisfactory results. I think it well, without some marked indication to the contrary, to combine with it a minute dose of opium, to allay in some degree the local tenesmus of the gut. When used in this way, I prescribe double the quantity that I would by the mouth. The best menstruum is cocoa butter, and after the introduction of the suppository within the sphincter, the buttocks should be pressed firmly together for several minutes. It will be well for you to remember that these suppositories may so irritate the lower bowels as to simulate dysentery.

You will frequently have occasion to use quinine hypodermically, and usually with good results. The best location for the injection is the buttocks. The dose should be from a half to two-thirds of that for the stomach. I have always used the bisulphate, which, with the addition of a little heat, is soluble in eight parts of water.

Quinine has also been used by inunction, with some oleate as a menstruum, but rather in chronic than acute cases.

When you have a temperature of 106° F. of undoubted malarial origin, and there are no immediate complications apparent, use quinine hypodermically, and repeat it in an hour if required.

3. *Antipyrine*.—The last of the internal remedies I shall call your attention to is antipyrine. During the past year or two it has been used quite extensively in this country, and for some time previously in Germany. There seems to be no special indications for its use, excepting a high temperature regardless of its cause. It may be given by the stomach, by the rectum, or hypodermically. The best way to give it is in three successive doses at hourly intervals, which can be repeated in six hours if necessary, and for a child under seven

years of age the dose, to begin with, is one grain for every one and a half years of the child's age. This dose should be doubled in the second series of these doses. Usually, however, the temperature remains down several degrees for about eighteen hours after the first series of these doses, and then does not reach its previous height. If given in an enema, double the quantity should be administered at the same intervals. If given hypodermically, half the quantity dissolved in warm water can be used.

You can reduce any temperature, and that, too, with a remedy which you will always have at hand wherever you may practice medicine—*i. e. water*. Furthermore you can reduce the temperature safely and prolong, if not save, the life of the little patient; at least you will not have done your duty until you have made every effort to reduce the high temperature which is killing the child.

*Sponging*.—This is the easiest and frequently a very efficacious way of using the water. If you have a temperature of 105° F., with no serious complications impending, you can have the child's clothes removed, and place it on the smooth surface previously mentioned (with a rubber sheet beneath the cotton sheet), and with water at 90°, commence to sponge the thorax and abdomen, and at the same time, have the water gradually cooled down to 70°, turning the child first on one side and then on the other, so that the back can be frequently sponged. Do this for thirty minutes, and you will probably find the rectal temperature down to 102° or 101°; if so, I usually wring out a piece of muslin, long enough to reach from the shoulders to the hips, in equal parts of whiskey and water, to which a little ground mustard has been added, and wrap this around the child's body; then covering the child with an ordinary sheet, allow it to remain in this way for one or two hours. If, at this time, the temperature remains down, the child can be removed to a dry surface, but not dressed for at least three hours more, when, if temperature still remains down, it can be lightly dressed. During all this time, cloths dipped in ice water should be repeatedly applied to the head, and, if the child is comatose, a hot flaxseed poultice sprinkled with mustard, is kept applied to the nape of the neck. If the heart's action is feeble or irregular, I usually take a small sponge moistened in hot whiskey and water, sprinkled with mustard, and apply it over the pericardium for ten or fifteen minutes. During all this time the extremities have been kept warm as previously described. In the meantime, the child has taken whatever nourishment it desired. Now, if malaria was the cause of the high temperature, primarily you should administer quinine in some one of the ways I have already described; or you can keep the child in this way—*i. e.* undressed,



and when the temperature goes above 103°, either sponge it again or apply the whiskey-water sheet. However, if the temperature repeatedly goes up, after being thus reduced, it will be better to put the child either on a rubber coil or a rubber cot, which I will soon describe to you. I think this one of the most practical and feasible ways of reducing a high temperature in ordinary practice; the parents and friends, however sceptical cannot object to it, for they see you commence with warm water, which you have gradually cooled, under the pretence that "the body is so hot that you must add ice to keep the water the same as when you commenced."

*Douche.*—When you have a temperature of 106° or 107°, with the child either in convulsions or profoundly comatose, more rapid work than the preceding must be done. In three cases of this kind, I have improvised a Kibbe cot, with two chairs, a blanket, and a sheet. The chairs with square-top backs, are placed back to back, about thirty inches apart, and over the tops the blanket is tightly stretched, and fastened with large safety pins to the centre cross-piece, in the back of each chair, respectively; then on this blanket the sheet is placed, and the undressed child on the sheet; beneath the blanket, and between the chairs, there is a small bath tub. It is well to place a thin sheet over the thorax and abdomen of the child, so that the shock will not be so great. When everything is in readiness, and you can do it all in the time I have been describing it to you, take water at a temperature of 90°, and pour it over the thorax and abdomen for three or four minutes, gradually having the water cooled down to 75° in the meantime, and there will be signs of returning consciousness within a few minutes. Within five minutes, the thermometer in the rectum will show a fall of four or five degrees in the body temperature; and here again keep the extremities warm. You can protect the legs from the water by a sheet tightly rolled up and placed under the thighs. If you put your hand underneath the blanket, over the middle of the back, you will be surprised to find the amount of heat there. Leave the child on this cot several hours. Perhaps, after several hours, the temperature will go up again: if so, then again apply the douche, but only for two or three minutes. One advantage in using the water in this way, is that you have it under your complete control, so that if there are any appearances of shock, you can apply warm or hot water instantly, and that too, without moving the child. Of course you are to use this method only in desperate cases, and in families of intelligence, and with their full consent, after you have explained to them the gravity of the case.

*Enema.*—In cases where you must reduce the temperature very rapidly, enemata of cold water,

a gill at a time, repeated every ten minutes, will do well in some cases. I have used it in one case with a temperature of 107°, caused by malaria. The infant was in convulsions when I was called in, and a syringe being at hand, I immediately gave it an enema of cold water, and repeated it in five minutes, after which the convulsions ceased; the enemata were repeated every ten or fifteen minutes for an hour, at which time I had obtained a solution of the bi-sulphate of quinine, which I gave hypodermically, and the high temperature or convulsions have not since re-occurred. I should advise you to use it only in similar desperate cases.

*INDIRECT APPLICATION.*—This method of using water in reducing high temperatures in young children consists in the use of tubing of rubber (lead or copper might be used) through which water is passed either from the hydrant or a syphon. The most convenient way of using it is to attach one end of the tube—i.e. the receiving tube to the water faucet of the hydrant, while the other end, or the discharging tube, is placed in the basin of the hydrant. The temperature, or degrees of cold, applied to the skin of the patient can be regulated in four ways, viz.: 1. By the temperature of the water used; 2. By the force applied to the stream in passing through the tube; 3. By the thickness of, and covering over (as sheet or blanket) the tube; and, 4. By the amount of clothing on the patient.

## A NEW BANDAGE FOR FIXATION OF THE HUMERUS AND SHOULDER-GIRDLE

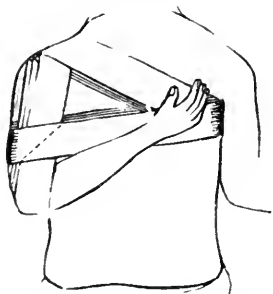
Dr. Dulles, of Philadelphia, gives the following in the *Medical News*:—

In the treatment of injuries about the shoulder-joint, such as luxation, contusion, fracture of the clavicle, or of the acromial end of the scapula, etc., I have often felt the need of some form of bandage, which, while as efficient as the Velpeau or Desault bandage, should be less cumbersome; and I have been led to try various modifications of these until I hit upon a way of bandaging which has been so satisfactory to me and my patients, that I wish to bring it to the notice of my professional brethren, and to obtain their judgment upon its merits.

This form of bandage requires, for an adult, a roller about three and a half inches wide, and about ten or twelve yards long. It is applied as follows: The arm of the injured side should be placed against the chest-wall, almost in the perpendicular line, but with the elbow a little in advance, and the forearm flexed at a right angle and laid across the lower part of the chest. A large piece of lint, or a soft towel, or a piece of old muslin, should now be interposed between the arm and the body, going well up into the axilla, so as to

prevent the excoriation which usually results from the apposition of two skin surfaces.

Then the surgeon, standing behind the patient, and a little toward the injured side, should apply the initial end of the roller to the axilla of the sound side, and carry the bandage diagonally across the back to the top of the shoulder on the injured side; then straight down the front of the arm to the point of the elbow; then under this to the back of the arm; then up behind the arm to the shoulder, where the preceding turn crossed it. At this point a firm pull should be made on the bandage, to draw the humerus well up against the glenoid cavity. In cases of fracture of the clavicle or scapula, this piece can easily be regulated so as, with the aid of a little manipulation, to place and keep the ends of the bone in position. Then the bandage is to be carried diagonally across the front of the chest to the axilla of the sound side; then through this axilla to the back; then horizontally across the back to the lower third of the arm of the injured side, and round this to the front of the arm; then across the front of the chest to the axilla of the sound side, leaving the forearm out; then through this axilla to the back near the point of starting. The appearance of the bandage is



shown in the figure. The bandage is completed by repetition of these turns till the roller is used up, advancing with each turn a little way up the shoulder, and a little way up on the arm. If one roller does not suffice to give the support desired, of course a second must be added.

After the bandage is in place, a few large pins should be inserted at each crossing, and the hand and forearm should be supported by a sling. In addition to the pins, the bandage may be stitched so as to make a firm case; or a few strips of adhesive plaster may be applied along and across it in different places, which will give the greatest possible security. It is a good plan to attach a strip of adhesive plaster, an inch and a half wide, from just below the shoulder, over the outer side of the arm and round the point of the elbow, to about the middle of the forearm. This will prevent the bandage from slipping off the elbow. In certain cases it is advisable to include the forearm in the bandage, so as to bind it firmly to the chest-wall. But one of the special advantages of this method, in

my opinion, depends upon the fact that it can usually be employed without including the forearm.

This form of bandage accomplishes the following results: It fixes the scapula and the outer end of the clavicle, holds the head of the humerus well up against the glenoid cavity, and fixes the whole bone against its natural splint, the chest wall. Among its advantages the most important, in my opinion, depends upon the exactness with which, by drawing up the humerus in the line of its axis, the bone and the shoulder-girdle can be held in a position in which there is the least muscular interference with the proper position of the fragments in a fracture of the scapula or clavicle, or of the different bones in a luxation at the shoulder-joint. I find that, with a little manipulation with my free hand, and careful regulation of the upward pull upon the humerus and the downward pressure upon the scapula or clavicle, by means of the bandage as it goes along, I can get all that I can ask for in the way of correct anatomical relation of parts. The position of the humerus, which I have indicated, is also, I believe, a better one than that which is maintained by the bandage most frequently employed—I mean the Velpeau bandage. The comparative lightness of this dressing is also an advantage, as well as the fact that it leaves the upper and lower ends of the arm uncovered, so that they may be examined at any time, or have applications made to them. The freedom of the forearm I have already alluded to as an advantage whenever it is admissible. There is no danger of the bandage slipping, if it be snugly and firmly applied, and if it be wide enough. It is easy to make it fit nicely at the elbow, so as to hold up this in a sort of cup made by the slight elasticity of the material. It is also easy, by varying the position of the turns, to make the bandage cover any particular point in the scapula, or in the outer end of the clavicle, or in the humerus. In fractures of the clavicle, or scapula, a suitable compress may be placed over the seat of fracture; while, in any fracture of the humerus, to which such a dressing is suitable, the arm may be splinted against the chest-wall by carrying the horizontal turns high up. I will not attempt to speak of the conditions to which this form of bandage is applicable, but I think they are all those in which fixation of the arm and shoulder-girdle is the important object. I am aware that it is somewhat dangerous to call anything new in these days, but I have so designated the bandage I have just described, because I have not met with any description which corresponds to it. If I am mistaken, I shall be happy to be corrected.

HOLMES says that charlatanism hobbles on two crutches, "the tattle of women and the certificates of clergymen."

## THE EXTRACT OF MALE FERN IN TÆNIA.

Behrens eulogizes the extract of male fern as by far the most efficient anthelmintic of the Pharmacopœia, and in the *Deutsche Medizinical Zeitung* of January 7, 1886, reports its successful employment in fifty two cases out of fifty-three treated. Fifty patients discharged the tapeworm after having taken a single dose of 5 grammes (75 grains): of the three remaining patients, two discharged the worm after one more dose of the drug. In two instances the heads of the worms were found. This rather remarkable success in the treatment of tapeworm Behrens believes to be attainable only if a certain methodical procedure is observed. The patient is, on the preceding day, not allowed to eat anything after dinner except a salted herring in the evening; for the thirst thus occasioned beer is allowed. On the following morning the patient takes the drug on an empty stomach, according to the following formula:

R—Extr. filic., . . . grm. 5.0 (75 grs.)  
Gum arab., . . . " 2.5 (37½ grs.)  
Aque dest., . . . " 5.0 ( 1½ f 5)  
Syr. simpl., . . . " 15.0 ( ½ f 3). M.

Sig.—Take at once.

A quarter of an hour after, f 5j. of castor oil is taken.

This drug, which for its anthelmintic virtues has been known ever since the days of Pliny (who advocates its association with scammony), is well deserving of the author's praise.

In this connection it occurs to us that male fern, at the close of the last and the beginning of this century, formed an ingredient of several nostrums which enjoyed great repute for their vermifuge properties. It constituted the specific of Madame Nouffer, the widow of a Swiss military surgeon, who received eighteen thousand livres for the publication of its composition: later it was the Herschwend remedy, and finally the specific of Matthieu, the Berlin apothecary, who sold it to the Prussian government for the prize of a title and a pension. The medical college of Würtemberg likewise bought and paid amply for this therapeutic secret. In all these cases drastic purgatives were given, either along with or after the preparation of fern.

In tænia lata (bothriocephalus), or unarmed tænia, the drug is far more efficient than in tænia solium, or armed tænia; hence we find the drug especially esteemed in Russia, France, and Switzerland, where the former variety prevails.

So much stress is laid upon systematic administration of male fern by all who have used it most extensively, that we shall describe several of the most approved methods, as cited by Stillé. Waw-

ruch treated two hundred and six cases, nearly all of tænia solium, according to the following plan:

*Preparative Treatment.* During four to five days a solution was given every day containing 20 grains of chloride of ammonia, the patient meanwhile taking no food but a thin broth at each meal.

*Expulsive Treatment.* The night previously a simple injection was given. The following morning a bowl of thin soup without salt was eaten, followed in an hour by two ounces of castor oil in two doses. In the interval between these from ½ to 1 drachm of powdered male fern was given in two or three doses, and an enema of milk and oil. Some time after the last dose of fern a drastic purge of calomel and gamboge was given, and under its operation the tænia was generally discharged. This method occasioned a good deal of pain, and often vomiting, rendering the use of emollients and narcotics necessary.

The treatment of Albers, of Bonn, and which proved successful in a large number of cases, was almost exactly the same as that just described, except that the ethereal extract was the preparation of fern employed. Lambert preceded the administration of the fern by a diet of herring, onions, and similar crude articles. Trousseau's method, which, he states, was very successful, is as follows: First day, absolute milk diet; second day, 15 grains of the ethereal extract of male fern to be taken fasting, and repeated every half-hour until four doses are taken; third day, repetition of the extract as on the preceding day. After the last dose about 2 ounces of syrup of ether, and, in half an hour later, an emulsion containing 3 drops of croton oil.

Peschier used the oil (volatile extract), and in doses of from 8 to 25 drops, and cured one hundred and fifty cases in a short time with it. Ebers, of Breslau, uses the alcoholic extract; Fouchon, of Nentchéâtel, the oil in gelatine capsules. The simple powdered root, however, is probably the most eligible preparation.—*The rap. Gazette.*

## VARICOSE VEINS.

Varicose veins are frequently exceedingly troublesome and sometimes dangerous, and we therefore draw the attention of our readers to an article which appeared in the *Brit. Med. Jour.*, by Dr. J. F. Fry, strongly advocating the removal of a considerable length of the varicose veins, as first proposed by Dr. Steele, of Bristol, and Mr. Marshall, of London, in the *Lancet*. Perhaps the method of operation can be most readily understood by reading a description of its performance as detailed by Dr. Fry:

An ink-mark about an inch long was made over each of the two varices (one near the ulcer, the

other above the knee), and, the patient being under the influence of an anæsthetic, an Esmarch's rubber bandage was firmly applied from the toes to the middle of the thigh, and removed after a Foulis's tourniquet had been placed round the thigh at the upper margin of the bandage. The limb was now bloodless. Under carbolic spray (one in forty), a longitudinal incision was made through the lower ink-mark, but only skin-deep, and extending into the ulcer. The tortuous varix next was dissected out and ligatured above and below, and thus a piece of vein six inches long was removed through an incision one inch in length. The edges of the skin were brought together with silver-wire suture, and antiseptic dressing applied. The second varix having been treated in the same way, the limb was firmly bandaged and (after the tourniquet had been removed) swung in a Salter's cradle. During the first three days the temperature ranged between 99° Fahr. and 100° Fahr., and then fell to normal. The wound was dressed antiseptically on the third, fifth, and eighth days, and on the last date the sutures were removed.

The conclusions reached by Dr. Fry are as follows:—If palliative measures afford sufficient relief, it is unwise to operate: but of the various operations the excision of the vein is the safest, and for its successful performance the following details must be strictly carried out:

1. Excise through several small incisions (not more than an inch in length) in preference to removing one large piece, as by so doing the vein is occluded at several points.

2. Mark the site of the proposed incisions before applying the bandage, as the position of the varices becomes indefinite when the limb is rendered bloodless.

3. Apply the Esmarch bandage carefully, so as thoroughly to empty the blood-vessels: or, the wound becoming full of blood, there will be considerable difficulty in dissecting out the vein, and very troublesome hemorrhage may occur.

4. Ligature the vein at its upper end, and dissect it out from above downwards.

5. Remove as little as possible of the tissues surrounding the vein: but if this be unavoidable, take away also the deep fascia (which is but feebly supplied with blood, and will not favor union), and allow the skin to adhere to the vascular muscle.

6. Apply the dressings and bandage the limb before removing the tourniquet. By this means hemorrhage is avoided and primary union encouraged.

7. Above all, the careful employment of antiseptic measures is necessary, both during the operation and in the subsequent dressings. — *Therapeutic Gazette*.

RECENT OBSERVATIONS ON NUX VOMICA. Dr. John H. Musser read a paper at a late meeting of

the Phila. Co. Med. Soc. (*Med. News*), "On the influence of age on the dosage of Nux Vomica, with some remarks on its therapeutics," in which he says: Going over the notes of some fifty cases, I find that at from 15 to 40 years of age 45 drops or more of the tincture were almost invariably well borne. After 40 years it was the exception to be able to increase the dose over 35 drops without causing disagreeable symptoms.

One of the patients, aged 24, took 200 drops three times daily with most decided benefit. To another, aged 16, 125 drops were exhibited without experiencing any bad effects. On the other hand, a male, aged 60, could take but 20 drops, and not one over 50 could get beyond 35. Patients aged 16, 24, 28, 35 and 40, took 40, 55, 30, 45 and 45 drops respectively before any therapeutic benefit could be seen.

Two effects of large doses of the drug were observed, that, under certain circumstances, would be disadvantageous—the production of diarrhœa and of frequent seminal emissions. Small doses of laudanum would readily control the former, although it is rare that the case would demand such very large doses. The latter symptom could not well be remedied. In mental and psychical depression due to prolonged excitement this drug is of value. One of my students took from 600 to 800 drops of the tincture daily, and thereby successfully tided himself over a period of great strain. In fact, he studied harder and kept later hours than at any other examination period, and with less detriment to his health. He is myopic and astigmatic, and this was the first time he came out of his studies without suffering from eye-strain. The doctor writes me that he has used the drug since, in practice, under similar circumstances. For instance, he helped along well a young society girl, who was unusually busy with engagements, until the rush was over. These uses of the drug are as dangerous, however, as those of any stimulant, and it should be given only on extraordinary occasions for the purpose indicated. Its use as above serves to show its power as a nerve stimulant. It has recently been the custom of students of medicine to take caffeine to keep them awake for study. My observations of the students who had taken one of these drugs was favorable to the use of nux vomica. The ones who took it came off with much better health and less nervousness than the caffeine-eaters.

The following are some of the conclusions which may be drawn from the above statements:

1. The effects of nux vomica are in inverse proportions to the age of the patient, the susceptibility increasing with the age.

2. The usual doses of the tincture indicated in the text-books are inadequate for many practical purposes, and do not represent the usual dose of strychnine.

3. It is a powerful and rather transient stimulant.

4. The best therapeutical effects can be secured in many cases only by pushing the drug almost to the physiological dose.

5. The system soon becomes accustomed to its use, and the dose must be increased.

6. The good effects in dyspepsia are largely due to its power to heighten reflex excitability.

**RECENT METHODS OF TREATMENT OF THE ASPHYXIA OF NEW BORN CHILDREN.**—Dr. Wm. L. Reid (*Glasgow Med. Jour.*), gave the following different methods of restoration :

1. Marshall Hall : The patient is turned face downwards so as to press on the chest and cause expiration, then turned on the side so as to free the chest from pressure, and produce inspiration by means of the elasticity of its walls.

2. Howard : The arms are extended, the wrists being brought together over the head and the chest thus expanded. The lower ribs are then alternately pressed on and relieved from pressure so as to cause expiration and inspiration.

3. Sylvester : The arms are raised upwards and forwards for a few seconds, and then pressed firmly down against the sides of the chest. By means of their muscular attachments the ribs are raised and air is sucked in, which is expelled when the arms are brought down again.

4. Pacini : The feet are fixed, and the operator standing with the head against his own abdomen, seizes the arms at the axillæ and pulls the shoulders upwards and forwards, then allowing them to return to their former position.

5. Bain : The shoulders are raised by lifting the body a foot off the table by seizing its hands. They are then allowed to fall back again, thus causing alternate expansion and contraction of the thoracic cavity.

6. Schücking : Like Sylvester's, except that he carries the arms outwards as well as upwards.

7. Schüller : The operator puts his fingers under the edges of the ribs, and pulls them up, afterwards depressing them.

8. Schroeder : The body is supported by one hand placed under its back, allowing the head, shoulders, arms, and pelvis to fall backwards with the view of producing inspiration, expiration being caused by sharply bending the body forwards so as to compress the chest and abdomen.

Lastly, Schultze's method : The child is to be suspended a few inches from the floor by the two index fingers placed in the axillæ from behind, the thumbs lying loosely over the front of the thorax, and the other fingers spread also loosely over the thorax behind, the head being supported against the edges of the ulnar bones. Without delay in

this position, the child is swung sharply upwards, until the operator's arms are extended horizontally, then the upward movement is continued more gently so as to bring the legs slowly past the perpendicular and allow them to sink quietly against the front of the child's body. The weight of the latter is now supported by the thumbs in front of the thorax, and the chest pressed on all round by the fingers, and its arms laid against its sides. This compression through the diaphragm below, and by the fingers all round, causes aspirated fluids to flow freely from the mouth and nose. After being retained in this position a few seconds, the body is swung smartly down again into its former position, taking care that now there is no compression of the chest, either before or behind, but simply a suspension of the child on the index fingers. During this movement the contents of the abdomen, partly by gravity, and partly by centrifugal force, fly away from the diaphragm, and dragging it down, enlarge the chest from below. At the same time the arms are separated from the sides, and by their muscular attachments drag the ribs upwards, and in this way air is sharply drawn into the lungs. These movements are continued every four or five seconds, unless when a considerable quantity of fluid continues to come from the mouth and nose, when the movement of expiration is on that account prolonged.

#### CONTRIBUTION TO THE STUDY OF MORPHIOMANIA.

—Dr. Marandon de Montyel summarizes the results of his investigations of the production of morphiomania as follows :

I. Morphiomania has its origin either in a demand for intellectual excitation and psychical pleasure, or in the acquired habit.

II. Injections of morphia have as a result a double action : a benign and a special action upon the nervous system by which its natural function becomes impossible after a certain term without the assistance of the poison. These two effects are separate and distinct from each other : the second is manifested when the first is no longer exhibited. There are, then, two kinds of morphiomania : the one resulting in a temporary good effect, the other a vital necessity ; and after a variable period the cases of the first order pass over into the second.

III. This double action of morphia upon the nervous system renders it an extremely dangerous medicament, and it therefore should not be prescribed hypodermically except in cases of absolute necessity.

IV. It is also extremely dangerous to combat morphiomania by the substitution of alcoholics, inasmuch as chronic alcoholic insanity may result therefrom.

V. Morphiomania may always be treated by abrupt withdrawal of the drug, except in conditions

when such methods are contraindicated by the vital forces of the patient or concomitant pathological phenomena. The method should also be abandoned if reactionary collapse result.

VI. In the treatment of morphiomania by gradual suppression of the drug, it appears advantageous to combine with the progressive diminution of the dose the recoil of momentum by fusing two injections into one.

VII. The medico-legal questions pertaining to morphiomania are certainly based more upon extrajudicial than upon judicial clinical observation.

VIII. Observation shows that a morphiomaniac may have great energy of will while the poison has not yet determined any disorder of intellect. There is here a serious proof of what has already been said, that responsibility only ceases with the period of psycho-physical marasmus.

IX. Relative to the responsibility of morphiomaniacs who commit crimes or offences to satisfy their passion, it is, perhaps, necessary to distinguish whether they have yielded to the simple appetite for a pleasant effect, or to a physical necessity dependent upon the instinct of self-preservation. A conclusion of irresponsibility in the latter case seems justified.

X. In the exact appreciation of the intellectual troubles caused by the abuse of the hypodermic injection of morphia, it is important correctly to appreciate the existence of predisposition to insanity, and the delirium produced concurrently by the absorption of other substances, such as alcohol and belladonna.

XI. It is necessary to retard the continual progress of morphiomania by disseminating general information in the upper ranks of society concerning the deplorable and certain evil effects following the use of the drug, and to exercise an active surveillance over pharmacists, and impose special penalties upon those who dispense morphia without a physician's prescription. *L'Euéphale*.

**DIPHThERITh PARESIS.** Dr Robert Bartholow, in a recent clinic says: This boy talks as though his mouth was full of hot mush, and when he takes a drink some of the liquid flows out of his nose. When he walks you notice that he cannot combine the action of the muscles of the two sides with any degree of certainty. You must remember that there is an automatic mechanism and a voluntary mechanism. If you start to walk from here to the river, you put into motion a set of muscles that will work automatically, without any volition or direction on your part. When, however, I tell him to shut his eyes, and, extending his arm, to bring his forefinger to his nose, he brings into play his voluntary mechanism, and this, you see, he can only do with some difficulty. But there is here also some derangement of the unconscious or automatic mechanism, as evidenced by

the failure of the veil of the palate to perform its duty, allowing the regurgitation of fluid. He has had diphtheria recently, and we have the sequel of paresis from head to foot. You must draw the distinction between paresis and paralysis, the former indicating only a partial, while the latter means an entire loss of power. If the faradic current fails, these cases will usually respond to galvanism, which should be employed until the reaction to the faradic current is re-established. If the muscles fail to respond to galvanism, then we know that the true muscular tissue is replaced by connective tissue and fat, but it is very seldom that we find cases so far gone. It is a singular fact that in many cases the muscles will respond to the stimulus of the will, even before the reaction to the faradic current is established. The use of electricity serves two purposes; it puts the muscles in use, and improves the circulation. If there is incontinence of urine, an urethral electro may be passed into the urethra, the non-insulated portion being placed at the neck of the bladder, and the other pole over the genito-spinal centre; the same procedure may be used for atony of the bowels. In bad cases I would use the alkaloid strychnine, hypodermically, one-sixtieth of a grain every day or two or three times a week; it will tone up the nervous system. In less severe cases I would give the same drug internally.

R. Strychnine. . . . . gr.  $\frac{1}{60}$   
Acid phosphoric dil. . . . . gtt. x. M.  
S.—For one dose, well diluted, thrice daily.

The general nutrition must be increased, which can be best accomplished, I think, by the use of officinal syrupus hypophosphatum cum ferro.—*Med. and Surg. Reporter*.

**COMPARATIVE ADVANTAGE OF DIFFERENT FORCEPS.** Dr. T. M. Madden says:—Among the changes which have recently taken place with regard to the forceps, there are two, however, which, I venture to think, require further consideration. The first is with regard to the early period of labor at which instrumental assistance is now advocated by some authorities. The second is with regard to the complicated form of forceps introduced by M. Tarnier, and since variously modified and largely employed by modern obstetricians. For my own part, I can see no reason for instrumental assistance before the os uteri is fully dilated, except in certain cases of complex labor, where immediate delivery may be necessary for the safety of mother or child, and in which it must be unhesitatingly resorted to as soon as the os uteri is sufficiently dilatatable. But if obstetric practitioners should ever come to regard it as a safe rule of practice to apply the forceps as soon as the os uteri can be sufficiently expanded to admit its introduction which in some instances may be done before the occurrence of any true

labor pains—it is very probable that the ill results of the indiscriminate and injudicious employment of this practice will outweigh all the possible benefits of its right use. The preference generally given to Tarnier's axis-traction forceps by many British as well as by nearly all French obstetricians, over instruments such as Barnes' original double-curved or my own short forceps, appears to me to be a mistaken one. In operative midwifery, as I have before observed, as in any mechanical problem, it is obvious that there should be a due proportion between the power used and the resistance to be overcome, and that the force employed should be the minimum necessary to accomplish the desired effect. This certainly is not the case in Tarnier's forceps, which I cannot but regard as a needlessly complicated, unwieldy, and, for the purpose for which it was designed, an ill-contrived piece of mechanism. Hence, in my opinion, this instrument is by no means equal to Dr. Barnes' forceps for any cases of difficult labor where the head is detained above the pelvic brim: nor, I will venture to add, to my own short forceps in those still more frequent instances in which the head, having entered the pelvic cavity, assisted delivery may be expedient, as I have found in upward of two hundred and fifty cases in which I have now used this instrument.

**MEDICAL NOTES.**—Prof. Da Costa relieved a boy, at the clinic, almost entirely, of a severe *torticollis*, in five minutes, by having injected over the sterno-cleido-mastoid, atropine gr.  $\frac{1}{60}$ , combined with morphine  $\frac{1}{8}$ .

Prof. Da Costa likes a combination of the bromides in the treatment of *epilepsy*, such as

R Potass. bromid. . . . . gr. x.  
Sodii bromid. . . . . gr. xv.  
Ammonii bromid. . . . . gr. v. M.

He also frequently prescribes, in the same disease, five grains of the effervescing bromide of nickel, *ter die*.

For a case of *leucorrhœa* and great *vaginal irritation* in a child of eighteen months, Prof. Parvin used with success—

R Extract opii.  
Extract belladonnae. . . . . aa gr.  $\frac{1}{2}$ .  
Iodoformi . . . . . gr. ij.  
Olei. theobroma. . . . . gr. v. M.

Ft. in vag. suppos., No. j.

Sig.—Use one every day.

Prof. Bartholow considers nitrate of silver at the head of the list of remedies for the treatment of the *diarrhœa of phthisis*. He recommends the use of the same drug in proctitis, applied by irrigation, in the strength of  $\frac{5}{j}$  to water Oj. If a stronger solution is used, it must be immediately followed by a solution of common salt.

Prof. Bartholow says the sulphide of barium is the best *depilatory* for ordinary use. Its long continued action often results in the permanent removal of the offending hairs. He advises the following, to be made into a paste, with sufficient alcohol, and put on the part and left till some pain is felt, then to be removed:

R Barii sulphidi.  
Calcis . . . . . aa  $\frac{5}{j}$ .  
Amyli pulv. . . . .  $\frac{5}{ij}$ . M.

For a marked case of *malarial cachexia*, with latent pleurisy, Prof. Da Costa prescribed the following:

R Tinct. ferri chloridi. . . . .  $\frac{f}{5}$  ss.  
Acid. acet. dil. . . . .  $\frac{f}{5}$  ij.  
Liq. ammonii acet. . . . .  $\frac{f}{5}$  ij.  
Elixir simplic. . . . .  $\frac{f}{5}$  ix.  
Strychniæ sulph. . . . . gr. ss. M.

Sig.—Desser. spoonful *ter die*, to be doubled slowly.

In addition, four grains of quinine, to be taken every morning *before* breakfast, directly after arising.—*Col. and Clin. Record*.

**PASTEUR ON THE SYMPTOMS OF RABIES.** A correspondent in Paris states that a person, bitten by a favorite dog recently, brought the animal to the Veterinary School at Alfort, to be examined, and carefully watched for some days; but, after the examination took place, the owner was informed that he could not receive an immediate answer to some questions he put, in conformity with the rules. He would have to come next day, and if the dog then presented no symptom of rabies, he would have to take it away. This not suiting him, he wrote to M. Pasteur, stating his case, and asking to be treated by him. M. Pasteur wrote back to him. As the hydrophobia scare appears to be spreading over the world, M. Pasteur's letter cannot fail to be read with universal interest: "Sir—Do not trouble yourself to call on me, because it would be useless. Every dog, whether it eats or not, that is attacked with rabies, dies in a few days. When it eats, death is delayed a short time, but that is all. It cannot live for more than ten days, and will probably die on the eighth. During the interval, rabid symptoms will be shown. Lock up your dog, therefore, and chain it. Be careful, in feeding it and cleaning away its litter, not to go within biting distance. If it survive the tenth day, you may have an easy mind. Meanwhile, attend to your wound: it should on no account be neglected. The saliva of a perfectly healthy dog may contain microbes which would cause an abscess. In very rare cases the bites of such dogs have caused septic blood-poisoning. If you find rabid symptoms in the dog, come at once to my laboratory, and I will be happy to treat you for rabies.—I am, etc., PASTEUR."—*Brit. Med. Jour.*



**THE WATER-COMPRESS**—Among the therapeutic measures in vogue in Germany there is none which attracts the attention of the American physicians so eminently as the water-compress. It is no fable that the "compress," as it is briefly called, is prescribed for every affection of the throat and lungs; for a clinical experience of nearly three months, in the Carité and other hospitals, convinced your correspondent that it is the first thing ordered in nearly every ailment of the respiratory tract. A piece of linen, being of the size of a napkin if intended for the throat, or of the size of a towel if intended for the lungs, is dipped into cold—not lukewarm—water, applied to the desired locality, and retained *in situ* by means of a woolen shawl or oil silk, and renewed every half-hour. A poultice is never exhibited for these affections. The compress, as may be expected, has also become the routine treatment in every household, and is quite familiar to every mother and nurse. Your correspondent has taken especial pains in tracing the therapeutic results of this procedure—which, of course, is often accompanied by medicinal treatment—and feels highly gratified with the results observed. The value of this hydriatic procedure consists in the frequent renewals and prolonged application—extending often over two or three days—of a medium which not only abstracts the surplus of heat in the part, and by its secondary physiological action dilates the vessels of the integument, and thus relieves the engorged internal parts, but which also has an undeniable invigorating influence on the nervous system. It seems superfluous to add that strict individualization is, as in all hydriatic procedures, an indispensable requisite in the application of the cold compress. *Therapeutische Gazette*.

**NATURE AND CURATIVE TREATMENT OF TRUE ANGINA OF THE CHEST**—Dr. Huchard, of Paris, after long study of the differential diagnosis between false and true angina pectoris, concludes that the latter uniformly depends upon changes in the heart, the aorta and other arteries, and that while it may be complicated by nervous influences it can not be produced by them. After trial of the various medicines for increasing arterial contraction, such as ergotine, or for increasing the blood-pressure, as digitalis, he rejects them as useless, and resorts to medicaments that have an opposite effect, such as nitrite of amyl, morphine, and nitro-glycerine, as of some use in the affection.

These, however, are regarded only as palliative. Dr. H. thinks the only actually curative treatment is with the iodide of potassium. This should be given steadily for from fifteen to eighteen months at least, with a daily dose of from fifteen to forty-five grains, even after the attacks have disappeared. Besides this there are accessory measures, such as vesicatories in the neighborhood of the

heart, and regulation of food and mode of life. Alcohol and all stimulating substances, as also tobacco, is to be prohibited, and a mixed or exclusively milk diet is to be prescribed. In advanced atheroma, cure is not at all to be expected, nor in most cases is improvement possible. — *Deutsche Med. Zeitung*.

**IODOFORM INJECTIONS IN KNEE-JOINT DISEASE.**—Dr. Piltz reports the case of a woman, fifty-eight years old, who had suffered from pain and swelling of the knee for about a year. In spite of active treatment the disease progressed steadily until the patient's health began to suffer. An exploratory puncture showed the presence of thin, flocculent pus. The author determined, before resorting to incision and drainage, to try the method of iodoform injection recommended by Mikulicz in the treatment of cold abscesses. The joint was punctured with a trocar and about a pint of pus removed, and it was then thoroughly washed out with a three per cent. solution of carbolic acid. After this, about two ounces of a ten per cent. iodoform glycerine emulsion were injected and an antiseptic dressing applied. No elevation of temperature followed the operation. The general and local effects of the injection were described as wonderful. The pain yielded at once, and merely a slight burning was felt in the joint. The operation was repeated, a smaller quantity of the emulsion being injected. After this no more pus was found and the patient continued to improve, regaining the use of the knee and increasing in weight. The author believes that this method might be advantageously employed in all joint diseases of this sort in which there is no lesion of the osseous structures. — *Allgemeine Medicinische Central Zeitung*, No. 94, 1885.

**COLD BANDAGING OF THE LEG IN INSOMNIA.**—Dr. von Gellhorn has found the following plan very useful in inducing sleep in persons who suffer from insomnia. A piece of calico, about eighteen inches wide and two and three-quarter yards long, is rolled up like a bandage, and a third of it wrung out in cold water. The leg is then bandaged with this, the wet portion being carefully covered by several layers of the dry part, as well as by a layer of gutta-percha tissue, and a stocking drawn on over the whole. This causes dilatation of the vessels of the leg, thus diminishing the blood in the head and producing sleep. It has been found by Winternitz that the temperature in the external auditory meatus begins to fall a quarter of an hour after the application of the bandage, and the normal is again reached for from one and a half to two hours afterward. Gellhorn has employed this means of procuring sleep for several years, and finds it especially useful in cases where there is congestion of the cerebral vessels. Sometimes

he has found it necessary to reapply the bandage every three or four hours, as it dried. *Med. Rec.*

**NEW OPERATION FOR THE ALLEVIATION OF PERSISTENT DEAFNESS.**—Dr. William H. Bates, of New York, in an article on this subject says that many cases of deafness are not benefitted by thorough catarrhal treatment, inflation of the middle ear, the use of Siegle's otoscope, an artificial opening in the drum-membrane, division of the tensor tympani, etc. He calls attention to an operation which has benefitted a number of these obstinate cases. The operation consisted in puncturing or incising the drum-membrane in from five to ten different places. Simple punctures were made, or the drum-membrane was slit in various directions. The operation was repeated as soon as the openings in the drum membrane had healed. The size and freedom of the incisions must be determined after the first operation for each case.

For the operation he employed a Graefe cataract-knife with a long shank. It is important that the knife be *sharp*, and to make this certain he often used a freshly sharpened knife for each puncture. Pain was avoided by this precaution. A dull knife, or the paracentesis instruments sold in the shops, caused more pain than the patients could bear.

Cocaine was not necessary when the knife-blade was in proper condition, and this remedy would not prevent pain when the knife was dull.

The result of this operation is to leave a number of cicatrices in the drum-membrane; the subsequent contraction of these producing a tension by which the membrane is drawn out. The membrane frees itself from adhesions in this manner, and in many cases loosens the ankylosed ossicles. The various benefits of paracentesis, as formerly employed, are not only obtained but much increased. It is not an improvement the result of a perforation of the drum-membrane alone, which, as is well known, is often doubtful and transitory, but the subsequent healing of the openings is part of an improving process. The operation, suggested by that of paracentesis, differs from it in the simultaneous number and extent of the incisions, as well as in the purpose for which it is resorted to, and in the immediate and subsequent results. *New York Medical Record*, January 23, 1886.

**TREATMENT OF FROZEN PERSONS.**—Medical men have always differed as to whether the best medical treatment of frozen persons was by a gradual or rapid application of heat. "To settle the matter," says *Knowledge*, "Lapchinski has made a series of very careful experiments upon dogs, with the following results: Of twenty animals treated by the method of gradual resuscitation in a cold room, fourteen perished; of twenty placed at once in a warm apartment eight died, while of twenty immediately put into a hot bath all recovered." The

experiments will probably influence the practice of medical men in Russia and northern Europe, where the question of the best means of restoring life in persons suffering from excessive cold is of frequent occurrence every winter. *Med. Summary*.

[Since learning of the above, or some other similar experiments, about three or four years ago, we have treated with uniformly marked success every case of frost-bite, of various degrees, that happened under our observation, by ordering the hot plunge bath or douche. For instance, if a foot was frozen to stiffness and almost total insensibility, it was immediately submerged in water, so warm that the hand at a normal temperature could not tolerate the heat. In case of frost-bitten ears, cloths wrung out in hot water were at once applied. The feeling is one of intense gratification, which usually is only momentarily preceded or interrupted by acute stinging pain. It is by far the most preferable method of restoration.] *Am. Med. Digest*.

**VACCINATION.** Among the many queries which the present extensive revival of vaccination has raised, is the one relating to the effect of vaccination upon one who has already had small-pox or varioloid.

We have been somewhat surprised to find that vaccination "takes" with those who have had small-pox, two or three such cases having come under notice. Upon inquiring of a physician, whose position at the Board of Health has given him a wide opportunity for observation, he assured us without hesitation that after small-pox, vaccination will take always, and in the primary form. Moreover, that vaccination is a surer safeguard from small-pox than small-pox itself, for he knew of instances where unvaccinated individuals had had the disease two or three times.

This information is therefore of great importance, for most people who have had small-pox feel that they are sealed with an immunity greater than a lifetime of continued vaccination could purchase for them.—*N. Y. Med. Record*.

**SUCCESSFUL PASSAGE OF AN OPEN PEN-KIFE.**—The following case (Dr. C. B. Hutchings, *Pacific M. & S. Jour.*, Jan.) illustrates the importance of giving bulky food when a sharp instrument has been swallowed. A man of 20 swallowed an open pen-knife  $3\frac{1}{2}$  inches long. On telephoning the neighboring doctor he was ordered milk and castor oil. This advice was, fortunately, not followed, but a hearty meal of mush and buckwheat cakes was given, and he was directed, on going to bed, to lie on his right side to facilitate the passage of the knife into the duodenum. He spent most of Friday, the next day, on the right side, and ate freely of any food desired, but particularly of

buckwheat cakes. The bowels moved on this day, but did not move again until the following Tuesday, when, after an immense movement, the knife came away point first. We publish the above item, not because the pen-knife was saved, but because it seems to show that there is at least one doctor in this country who adheres to the antiquated treatment by purgatives. Think of an open pen-knife traversing an empty bowel under castor oil.

**INFLUENCE OF ALCOHOL, BEER, BLACK COFFEE, TOBACCO AND SALT ON DIGESTION.**—1. Alcohol, even in small quantities, arrests the digestive processes. The digestion of albuminates is arrested more than the transformation of dextrine to grape sugar. Gastric juice, with 20 per cent. of alcohol, digests six to seven times smaller quantities than the normal secretion. This is explained by the precipitation of pepsin by the alcohol.

2. Beer does not promote digestion. It appears that this is due, not so much to its alcohol as to the large quantities of neutral salts that bind the free acids of the gastric secretion. If a few drops of hydrochloric acid are added, the beer no longer inhibits.

3. Wine in small quantities appears to promote digestion; in larger quantities its action is that of alcohol.

4. Black coffee also, when taken in small quantities, stimulates the digestive functions; large quantities act unfavorably.

5. Moderate smoking does not alter digestion. Excessive smoking, however, is of bad influence, because the tobacco derivatives—alkaline reaction of nicotine—neutralizes the gastric juice.

6. Small quantities of salt are conducive to the processes under consideration. Large quantities arrest them, probably by hindering the swelling of the food.—*Deutsche Med. Zeit.*

**CHAULMOOGRA OIL IN CHRONIC SQUAMOUS ECZEMA.**—Dr. W. L. Chew reports a case of chronic universal squamous eczema cured by this remedy. The patient had been treated with iron, arsenic, cod-liver oil, etc., with but slight improvement. The oil was then given in two or three drop doses, and increased to ten or fifteen drops three times a day. The best vehicle was found to be a goblet of sweetened cream. The oil was also used in the form of an ointment:

Chaulmoogra oil . . . . . 5 ii.  
Glycerine . . . . . 5 iv.

To be rubbed over the body and limbs, and the cold shower-bath applied three or four times a day.

In fifteen days all the exudation has been checked; on the nineteenth day the case was discharged cured.—*N. O. Med. and Surg. Jour.*

**POISONOUS GLOVES.**—We have recently had

several cases of a peculiar herpetic eruption about the lips of children, and which we have satisfied ourselves were due to cheaply dyed gloves. The children wearing these gloves rubbed their mouths with them. The rash could be produced at will. When the gloves were taken off and not worn for some time, there was no rash. When, on the other hand, the gloves were worn, and the children repeated the practice, the rash returned. Clearly it was a case of cause and effect. Owing to competition, manufacturers endeavor to cut down the expense of production by using the cheapest form of dye; and the public support them by buying cheap products. There is not much economy in this, however. The old proverb should be remembered cheap and dangerous.—*Provincial Med. Jour.*

**CARBOLIC ACID INTERNALLY.**—A practitioner of large experience sends the following:

In the few brief notes you have published on carbolic acid in indigestion, I think you have by no means stated the full range of the remedy even in this condition. In the first place, I have found carbolic acid in doses of from two to four drops a better antacid than any of the alkalies. It arrests fermentative action in the stomach, of whatever kind, with greater certainty, in shorter time than any drug I know of. And in sick stomach it often gives quick relief. In vomiting, from any of the usual causes, it is usually serviceable, and in some cases is of benefit where other remedies have failed. It frequently quiets the sick-stomach of pregnancy. I have used it almost daily in my practice for the past eighteen or twenty years, and know of no drug in which, in the conditions named, I put so much trust.—*Am. Prac. and News.*

Prof. Da Costa treated a boy at. 12, with *pericarditis with effusion*, following a very severe attack of chorea, as follows: Potassium acetate ʒss every two hours; tinct. digitalis gtt. v. every four hours; whiskey fʒij per diem; to insure quiet and sleep, a little paregoric at bedtime; do not interfere too actively with the bowels; the quieter in every respect the patient can be kept, the better; do not allow him to get out of bed under any circumstances as long as any effusion is present.—*Col. and Clin. Record.*

A YOUNG physician, who has just established himself, and has very little practice, is noted for his braggadocio. One of the older physicians, meeting him on the street yesterday, asked him how he was coming on. "I've got more than I can attend to," was the boastful reply. "I had to get out of my bed five times last night." "Why don't you buy some insect powder?" asked the old doctor.—*Ec.*

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

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Medical Journal in Canada.*

## HEMORRHOIDS.

There has been a great deal written of late regarding the proper treatment of piles, with little or no reference, however, to the kind of piles referred to. One writer suggests the treatment of piles by the use of the ligature, and another by the employment of the hypodermic needle, another by the clamp and cautery, etc. Writers should be more careful, when speaking of the treatment of piles, to specify the nature, pathology, and situation of the tumefaction under consideration. Any suggestion on the treatment of piles, without a proper understanding of its character, only serves to confuse.

The curative treatment of external piles is to lay them open and turn out the clot, or snip them off, and cauterize if bleeding occurs to any extent. Provided the pedicle is large and indistinct, the incision is the better treatment. After the blood has disappeared in the tumor, it may either be snipped off, or left alone if it is harmless.

An internal pile first makes its appearance in the form of a thickened, hard mass, with a granular surface, which is covered by a thin membrane, often breaking down and causing a gush of blood from the dilated capillaries. In this stage of the disease, the best treatment is to dilate the sphincter and apply nitric acid to the granular surface: a wire speculum being used to dilate, in order that a proper application of the nitric acid can be made. After this condition of the hemorrhoid exists for a

longer or shorter time without cure, it gradually forms into a distinct tumor, the mucous membrane becomes thickened, the bleeding ceases, the connective tissue is increased, the capillaries are finally closed, the tumor enlarges, and a more or less tumor-like mass results, which may finally protrude through the sphincter in straining at stool. In this tumor the capillaries are in a manner obliterated—the mucous membrane, arteries, veins, and connective tissue, forming the tumor. The result of these tumors protruding through the spineter is well understood, and also the palliative treatment.

The curative treatment of this form of internal piles should vary with the appearance of the tumor. Provided the tumor is not very large and prominent, and is attached to a broad base of the mucous membrane, the injection of different fluids will afford certain and permanent relief. The injection is intended to reduce the tumor by setting up a slight inflammation, resulting in a gradual shrinking of the tumor, or cause it to slough, which is rare. Probably the best injection in use, and one that gives the least pain, is glycerine, water, and carbolic acid. This may be used in any proportion, but that which we prefer is six parts each of glycerine and water to one of carbolic acid. This solution may require many repetitions, but it gives little or no pain, and does not prevent the patient from attending to his ordinary duties. The injection is made with a common hypodermic syringe, the needle being thrust well into the tumor. The injection may be made every five or six days till the tumor disappears. In our hands the hypodermic plan of treatment has been the least objectionable to the patient, and the most satisfactory to us in selected cases.

The operation by means of the ecraseur, or clamp and cautery, is quite safe, so far as the immediate and curative results are concerned, but it will often leave a cicatrix that may subsequently give trouble; hence we do not practice it. The ligature treatment is probably more satisfactory than any other in the majority of well-defined hemorrhoidal tumors. It leaves little cicatrix, and gives permanent relief. The patient should be anesthetized, placed in the lithotomy position, and the sphincter thoroughly but gently dilated with the fingers till its contractile power is completely lost. The tumor is then easily drawn down with a

toothed forceps, and is ready for treatment. If the tumor is large, it should be tied with a strong silk ligature, doubled and passed through the centre of the base, tying each segment separately. The hemorrhoid is then cut off a short distance from the ligature; provided, however, the tumor is not too large, a strong ligature tied tightly around the base answers every purpose. Great care should be taken to not remove too much of the hemorrhoid with the knife, for fear of cutting the ligature or causing it to slip. A suppository of opium, belladonna, and coca-butter—two grains each of pulv. opii. and ext. belladonna, and four of the butter of coca—is then introduced, and the patient put to bed and kept quiet for several days. The bowels should be opened by mild laxatives within four or five days.

Hemorrhoidal tumors vary so much in their appearance and character that they can not all be successfully treated alike. One pile can best be treated by the hypodermic injection, and another by the ligature in the same individual. In timid persons who have a dread of surgical operations, we would advise the slow, patient, and less offensive treatment with the hypodermic solution. When persevered in, it will cure most of the worst forms of piles with little pain to speak of, and no danger or inconvenience to the patient, provided the weaker solution is used.

### EMPIRICISM IN MEDICINE.

Many a thoughtful physician probably, in intervals of leisure, when his mind is withdrawn for a time from the usual routine of his practice, is accustomed to reflect upon the progress and present state of the profession which he has adopted. If he is a reader and keeps abreast of the times; above all if he is himself an original investigator, and takes delight in discovering for himself the secrets of nature, the more often probably, will he allow his mind to dwell upon the more scientific or theoretical part of medicine.

As a rational man, as one to whom the public looks, not only as being a person devoting his life to the mitigation of suffering, but also as a person devoting his life to the discovery of the laws of suffering, this occasional review of the progress, and consideration of the present standing, of the science and art of medicine is a duty. If every

medical practitioner in the world thought of nought else but the *practice* of his profession, its *science* would lamentably decline. Nevertheless there are evidences, we think, that even in these days there is exhibited far too much apathy upon this subject. True, medical works and magazines abound, and discoveries and inventions do much more abound; but this does by no means necessarily imply, that a real knowledge of the workings of nature in health and disease is making true progress. And for this reason: These discoveries and inventions may be, and often are, purely empirical. For example, by mere accident—by what might have eventuated in a grave error—it is found that the injection of ergot is as efficacious as that of iodine in hydrocele. What have we learned? Merely that in the next case of hydrocele which we have to treat, it will be immaterial whether we inject ergot or iodine.

This is a typical, though extreme, example of the way in which many advances have been made in medicine. They are truly empirical. Certainly, wonderful discoveries, thanks to the microscope, have been made, and legitimately made, by other and more logical methods. Still it remains true that these have not been as numerous as our hopes might have suggested. Where then lies the remedy? This is no easy question to answer. A few suggestive hints, however, may be hazarded.

Every variety of natural law, operating in health or disease, may be reduced to one of two classes: Chemical, or Physical. The term "vital processes," we know, is used; but what "vital" here truly means, we hesitate not to assert, no one can define. The only fields of investigation open to us are chemical and physical fields. If we are right in this, then the only rightful conclusion to be drawn is that, if we desire to see the science of medicine advance by the only path in which it can properly advance, we must devote our energies very much more in the future than we have done in the past to attaining a more accurate knowledge of nature in her chemical and physical aspects. That is to say, instead of resting satisfied with the fact that quinia is a specific for intermittent fever, that mercury is a standby in syphilis, that aconite lowers the temperature, and so forth, let us not remain satisfied with any such facts, learned purely empirically, but let us betake ourselves to our laboratories, and with retort and microscope ask,

Why are these things so? Only by a constant use of that word "Why," can scientific knowledge advance. It is necessary to seek for causes. Empirical knowledge is useful, very useful, but it does not exhibit reasons.

The subjects, then, to which we would strongly urge the younger members of the medical profession, and we address ourselves here more especially to physicians, to devote themselves in the future, are pathological histology and chemistry in relation to therapeutics—chemical therapeutics, if we may use the phrase. Let them try to discover what in its very essence is the action on the various tissues of quinia, of iodine, of aconite, etc., etc. This is the only method by which scientific progress can be attained, and we venture to believe that in a century or two from the present day this will be the only method followed.

#### ETHICS IN SURGICAL OPERATIONS.

In this age of thorough cleanliness and antiseptic treatment of wounds, there is a decided necessity for radical reform in ethics at surgical operations. Any and every surgical operation, no matter when or where performed, if on a human being, is for the benefit of the patient operated on, and not for the glory of the operator or for the instruction of himself or his *confrères*. To our sorrow, we have again and again seen the reverse of this obtain. It may be asked, how can men become experts in operating except by witnessing and participating in operations, and thus become familiar with the whole procedure in a practical way and verify every detail in a critical manner? We answer that the dissecting and post-mortem rooms, and not the operating amphitheatre, are the places to become expert in either making diagnosis or operating. No man, nor any number of men, no matter what be the pretext, have the least right to jeopardize the life of another human being—and that is what is constantly being done when a crowd is allowed, in an operating room to examine a wound that has just been made, or put the hand into a peritoneal, thoracic, or other cavity, without the operator knowing that that hand has been thoroughly cleansed and made aseptic.

This state of things is wholly wrong. If a physician is, through courtesy, invited to be present at an operation, he should remember he is only an

invited guest so far as viewing the procedure is concerned. To all else he is an intruder, and an abuser of hospitality when he interferes. Again, we have seen surgeons who, while operating, apparently as a matter of routine, invite every one present to examine the wound or cavity they had opened. Any surgeon who does such a thing is surely forgetting the high responsibility that rests upon him especially, to guard the life of his patient at every point, to the utmost of his ability. A surgeon fully imbued with the responsibility of his work will invite to assist him only such persons as he may require, and he *knows* are thoroughly clean and free from infection. Having made these selections, he assigns them to their several places about the operating-table. These, and only these should be allowed to take part in the operation, and they only to examine the wound or cavity in cases of extreme doubt on the part of the operator, or when he requires and asks advice. When the operation is done the wound should be subjected to no manipulating by by-standers, but be promptly closed.

This is the only way that antiseptics can be used to any purpose, or with good effect. A rather good thing was the answer of a surgeon to a brother practitioner, who asked if a certain operation had been done antiseptically. The answer was "Yes, somewhat." There can be no neutral ground in this question. Right is right, and nothing can make it wrong, and, wrong is wrong, and can never under any pretext be right. We are satisfied that the error spoken of is one of thoughtlessness, but it is none the less wrong and does just as much harm as if premeditated.

#### HALIFAX HOSPITAL MEDICAL STAFF.

During the past year a dispute took place between the "Board of Charities" or Commissioners, and the Medical Staff of the Halifax Hospital in reference to the appointment of the house surgeon. According to the by-laws of the Board "candidates for the position of house surgeon have to undergo a *competitive* examination before the Medical Staff, who shall communicate the result to the Board." Two candidates presented themselves, one of whom obtained eighty per cent of the total number of marks, and the other sixty-six. The "Board of Charities" however awarded the position to the

gentleman who obtained sixty-six per cent. The Medical Staff remonstrated against the action of the "Board," asked for an explanation, and receiving a very curt reply, resigned their positions on the Hospital Staff. This step also involved the closure of the Halifax Medical College. Friends of the Hospital and College at once stepped in with a view to restore harmony and prevent the closure of the school. At a conference of both parties it was agreed to submit the question in dispute to one of the Superior Court Judges. Some difficulty subsequently arose, however, as to the points to be submitted for the Judge's decision. The Board of Charities were willing to submit the question of their legal right to make the appointment they did, but not the propriety of their conduct in making it, and urged that there might be facts and circumstances which would justify them in the appointment of a candidate as house surgeon although he had not obtained the highest marks in a competitive examination. Of course the negotiations came to an abrupt termination, and shortly after, the secretary of the Medical Staff was informed that the resignation of its members had been accepted. The Board remained masters of the situation, a new medical staff was appointed, but the medical college was left in abeyance. The above is a bare outline of the facts of the case, so far as we can gather them, and we leave our readers to draw their own conclusions.

POISONING BY COCAINE. Perhaps in no branch of medicine are the lines of the poet,

"For man who knows no good unmixed and pure,  
Oft finds a poison where he sought a cure."

more applicable than in that which deals with the therapeutical action of drugs. It is not many years ago that the hydrate of chloral was introduced into medical practice, and soon its indiscriminate use led to its abuse in so many cases that by some it is held to be more an evil than a good. There appears to be a fashion in drugs as in most other things. The last new drug which bids fair to rival chloral in its wondrous diversity of applications is cocaine and its salts. The drug has been used in hay fever "with good success" in operations on the eye, tonsils, etc., but the latest application of this wondrous drug is recorded by Dr. Roberts, in the *New York Medical Journal*, who has performed two operations, one "femoral supra-

condyloid osteotomy for genu valgum" in a boy four years of age, the other "excision of the hip joint," both under the influence of superficial and deep injections of cocaine, *with no suffering to the patient*. It may not however be out of place here, amid all the enthusiasm which cocaine is creating, to enter a word of caution for the cases of poisoning by the drug are becoming neither few nor far between. Dr. Kennicott, in the *Chicago Medical Journal*, records a case of poisoning by the application of two-thirds of a five grain solution to both nostrils. The patient ultimately recovered, but not before considerable alarm had been created on her account.

MASSAGE IN THE TREATMENT OF INFANTILE PARALYSIS.—Dr. Murrell, in a recent lecture on the above subject (*Med. Press and Circular*) stated that after treatment during the acute stage of infantile paralysis by means of aconite, followed later on by physostigma and phosphorus, he recommended recourse to a carefully graduated system of *massage*, commencing with simple *effleurage* or surface rubbing, followed by *friction*, which is a more energetic application. As the case proceeds, kneading of the affected limbs or muscles is resorted to, and this is succeeded by, or combined with systematic *tapotement*, which is a form of percussion. This plan of treatment conscientiously carried out, has, when the case has not been too long delayed, been followed by excellent results, but it should only be done by the advice and under care of the medical attendant, as indiscriminate *massage* is likely to be futile and may be injurious. The operation should be conducted with dry hands on a dry skin, and all oils or other ununctions studiously avoided.

TREATMENT OF CONJUNCTIVITIS.—The idea that certain kinds of conjunctivitis are caused by microbes has been enlarged by Bieloff of Kiew (*Wiestnik oftalmology*), who goes so far as to say that all forms of this disease are attributable to living organisms, and especially to the gonococcus of Neisser. Acting upon this belief, he has treated some 65 cases of conjunctivitis of different varieties, with bichloride of mercury, with the happy results of an immediate amelioration of the symptoms, and eventually of a perfect cure in every case, in a shorter time than he could otherwise



have expected a cure to be effected. The corrosive sublimate acted as an abortive in acute forms, and in cases where some corneal lesion was present, and in which nitrate of silver would be consequently ill borne, it acted well in every respect. He never uses a stronger solution than 1 in 2000, or 1 grain in 4 oz. of water.

**CALCIUM CHLORIDE IN ENLARGEMENT OF THE LYMPHATIC GLANDS.**—Dr. Arthur Davies writing to *The Practitioner*, January, 1885, says that experience has shown him the great value of this agent in removing the enlargement of lymphatic glands, and especially when of a scrofulous nature. He instances one case of undoubted lymphadenoma in which a gradual improvement took place under the exhibition of large doses of the drug. In other cases, complete cures were effected, and the whole paper goes to show that this drug can be depended upon if properly administered. He advises it to be given in small doses three times a day, the dose to be gradually increased and continued for long periods. One patient, a male, æt. 37, took 40 grs. three times a day for the greater part of a year, though he began with a 10 gr dose, which was gradually increased. No untoward symptoms were developed. He considers it useless in cases of scrofulous diathesis where suppuration has already commenced.

**DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION.**—The rates given to the Delegates to the American Medical Association meeting, May 4, in St. Louis, have been fixed by the different Railroad Committees of the country, at one and one-third fares for the round trip. Delegates must pay full fare coming, and will receive on application, from the Agent at starting point, a certificate, which when signed by the Chairman of the Local Committee of Arrangements will entitle them to the reduced return rate. No reduced return ticket will be issued unless the purchaser can show a certificate issued by the Agent from whom he purchased the going ticket, and signed by the Chairman of the Committee of Arrangements.

LE GRAND ATWOOD.

*Chairman Committee of Arrangements*

**A NEW HYPNOTIC.**—Dr. Jasch, of Vienna, has introduced another new drug—*urethran*, to the notice of the profession. It was Dr. Jasch who

brought forward thallin, and though urethran was first used by Schmiedeberg, the credit of first thoroughly testing it belongs to the former gentleman. It is an ethyl-ether and has for its formula  $\text{NH}_2 \text{ CO}_2 \text{ C}_2 \text{ H}_5$ . It is a white, crystalline body, easily soluble in water, having no odor and a not unpleasant taste. Dr. Jasch experimented first on animals and then upon some twenty patients, making over a hundred separate tests. He found that fifteen grains acted as a sure hypnotic, that it did not produce nausea or any unpleasant after-effects. Its action resembles that of chloral but is milder. It does not affect the peripheral sensory apparatus, and does not therefore directly relieve affections of that apparatus. It produces natural sleep, is without danger, and he therefore thinks will be a useful drug, especially in the treatment of children's diseases.

**THE TREATMENT OF PEDICUL.**—Mr. W. Frazer, F.R.C.S.I. recommends the expressed oil of stavesacre as having in his hands "proved by far the most safe and speedy remedy" in *P. capitis* as soon as the embryo has escaped from its chitinous envelope. It can be applied diluted with six to twelve parts of olive or almond oil, and the mixture, if considered desirable may be perfumed with any of the aromatic essential oils, such as lemon, bergamot, lavender or rose. It is applied in the same manner as ordinary hair oil, and if liberally used a single application will kill every pediculus. The encapsulated ova which escape will become developed within a week or ten days, and an occasional application of the medicated oil at short intervals will destroy the entire race.

**ONTARIO MEDICAL COUNCIL ELECTION.**—Since our last issue we have been informed that Dr. Henry, of Orangeville, has come forward as a candidate for the representation of the territorial division of Saugeen and Brock in the Medical Council. There are therefore two candidates in the field: Dr. Herod of Guelph, and the above named gentleman. A spirited contest may be expected.

**EFFERVESCENT ENEMATA IN INTESTINAL OBSTRUCTION.**—The *London Med. Rev.* says that Dr. Vondrodsky details a case of intestinal obstruction of five days' duration, in which all the usual means of cure having failed, success followed the

introduction of effervescent enemata every few hours. The enemata consisted of two injections successively administered, of  $\mathfrak{v}$ ij of tartaric acid in a glassful of water, and  $\mathfrak{v}$ iv of sodæ bicarb in the same quantity of water. The cure was complete.

**MAURY'S OINTMENT.**—The above named ointment has been in use in the Philadelphia Hospital for a number of years in the treatment of sores, ulcers, and venereal affections of the skin. It was first used by Dr. Maury, a former visiting physician of the Hospital. The formula is as follows:

R Ungt. hydrary nit. . . . .  $\mathfrak{v}$ i  
 Pulv. rhei. . . . .  
 " opii . . . . .  $\mathfrak{z}$ ss  
 Cosmolini ad . . . . .  $\mathfrak{z}$ i—M.

Rub the rhubarb and opium with the cosmoline and add citrine ointment.

**LACTOPEPTINE.**—We have used this article for some time in cases of indigestion, and can recommend it as a valuable remedy. Being a compound of the five active agents which are contained in the process of digestion, it cannot fail to aid the system in preparing the food for assimilation. It is an invaluable remedy in the summer diarrhœa of children. Owing to the great impairment of the vital forces, and feeble powers of the digestive tract, food frequently irritates and increases the difficulty. For such cases we have no agent in the materia medica as reliable as lactopeptine.

**CARBOLIC ACID IN WHOOPING COUGH.** Dr. W. F. Cory writes to *The Lancet* that he has had remarkable success in the treatment of pertussis with carbolic acid, in as large doses as may be safely administered. He came to the conclusion that some antiseptic remedy would be beneficial from noting the effect that a greater or less amount of ozone in the atmosphere produced upon patients suffering from the disease, the whooping being aggravated when a small amount was present, and ameliorated under the contrary conditions. He advises that it shall be administered in tincture of tolu.

**THE IMPROVED METHOD OF OPERATING FOR CLEFT PALATE.**—One of the difficulties experienced in the operation of staphylorrhaphy, is the flowing of the blood into the stomach and lungs of the patient. It has been proposed to obviate this, as

well as to get the structures below instead of above the knife, by allowing the head to hang over the end of the table, or by so arranging the pillows beneath the shoulders as to bring the vertex of the cranium to rest upon the table.

**INJECTION FOR GONORRHOEA.**—Prof. Taylor recommends the following as an injection especially in the earlier stages of the affection:

R Bismuth. subnit. . . . .  $\mathfrak{z}$ j.  
 Morphiae sulph. . . . . gr. v.  
 Zinci sulph. . . . . gr. x.  
 Glycerini. . . . .  $\mathfrak{z}$ j.  
 Aquæ rosæ . . . . .  $\mathfrak{z}$ ijj. M.

S.—Inject three or four times a day.

**LOTION FOR DANDRUFF.**—The *Med. World* gives the following as a good remedy for this troublesome condition of the scalp:

R Tr. capsici, . . . . . 2 parts.  
 Glycerine . . . . . 8 "  
 Cologne. . . . . 2 "  
 Aq. . . . . 25 " M.

Sig.—Apply by means of a sponge every day.

**FOR PAINFUL HÆMORRHOIDS.**—Dr. Milx, in the *New Eng. Med. Monthly* gives the following as an excellent ointment for painful hæmorrhoids:

R Ext. hyose.  
 Pulv. saffron . . . . . aa  $\mathfrak{z}$ ijj.  
 Plumbi acetat. . . . .  $\mathfrak{z}$ i.  
 Glycerol. amyli. . . . .  $\mathfrak{z}$ i. M.

**A CURE FOR QUINSY.**—Dr. Fritzinger, of Philadelphia, writing to the *Medical Summary*, says the following will "absolutely cure every case of ordinary tonsillitis" if promptly used:

R Pot. chlor. . . . .  $\mathfrak{z}$ ij.  
 Tr. guaiac. . . . .  $\mathfrak{z}$ i.  
 Mel. dep. . . . .  $\mathfrak{z}$ i.  
 Aq. . . . .  $\mathfrak{z}$ iv. M.

S.—Shake well and take a desert spoonful every three hours in a tablespoonful of water.

**CHLORAL IN WHOOPING COUGH.**—This remedy says Joffroy (*Jour. de Médecine*), is the most reliable one we have for the treatment of whooping cough. He prescribes it in confection of currants which entirely disguises the taste. He considers 15 grains in twenty-four hours sufficient for children under 5 years of age, while in older children

30 grains and upwards may be administrated daily.

**FOR ITCHING.**—Dr. R. G. Gough (*Virginia Med. Monthly*), says the following will be found invariably successful in itching of cutaneous surfaces, whether the skin is whole or not :

R Sodæ biborat. . . . . i.  
Acidi carbol. . . . . gtt. xv.  
Glycerin. . . . . ʒi. M.

Sig.—Apply as a lotion with camel's-hair brush.

**COUGH MIXTURE FOR CHILDREN.**—The following will be found an excellent cough mixture for children :

R Tinct. opii camph.  
Spts. ammon. aromat. aa fʒi.  
Ext. ipecac. - - - fʒss.  
Syrup. pruni virgin., - fʒi.  
Aqua q. s. ad - - - ʒiij.

Sig. A teaspoonful four or five times a day.

**PAROTITIS AFTER OVARIOTOMY.**—Metastasis, with implication of the genital apparatus, is a well known complication of parotitis, and from a number of cases reported by German and other observers, the reverse process appears to take place in certain cases after ovariectomy. Nine cases have been reported in which parotitis has followed the operation of removing the ovary.

**SLEEPLESSNESS IN INFANTS.**—The following is recommended instead of the usual sedatives :

R Cod liver oil, - - - ʒiss.  
Syrup of saffron, - - - ʒss.  
Syrup - - - - - ʒj.

A tablespoonful four, five or six times a day. The therapeutic value of the above is due to the fact that the child is growing beyond its strength, hence the nervous wakefulness.

**BUTTERMILK IN OBSTINATE VOMITING.**—It will be gratifying to the profession generally, and to the country practitioner especially, to learn that buttermilk has been used (*Dr. J. H. Owings, N. Y. Medical Journal*) with entire success, in as many as fifty cases of this troublesome complaint. It is said to be especially valuable in vomiting brought on by debauch.

**ONTARIO MEDICAL ACT AMENDMENTS.**—Owing to the lateness of the session before the draft of

the bill was brought before the House of Assembly, Dr. Cascaden, who had charge of it, found it impossible to obtain the several readings before the adjournment. It was therefore withdrawn and will be re-introduced next session.

**BROMIDE OF POTASSIUM IN OVARIAN MENORRHAGIA.**—At a recent meeting of the Brit. Gyn. Soc. Dr. A. Meadows stated, that no drug is as powerful in its action on the ovaries as bromide of potassium, that it controls the overflow, and lessens the frequency of ovulation.

**ERRATUM.**—In the last issue of the LANCET, in Dr. Poole's article on Cheyne Stokes' Respiration, page 199, inside column, fourth line from the bottom, for the words "the nervous system," read "in the Venous System."

**PERSONAL.**—Dr. T. R. Buckham, of Flint, Mich., author of "Insanity in its Medico-legal Aspects," has been elected a Fellow of the Society of Science, Letters and Arts, London, Eng. We congratulate our old friend on this mark of distinction.

**STRYCHNINE TO PREVENT FLOODING.**—It is said strychnine and iron administered for a month before labor, has exerted a remarkable influence in preventing *post partum* hemorrhage where severe flooding has occurred in previous labors.

We regret to announce the death, on 13th March, of Dr. Austin Flint, Sr., of New York, also that of Dr. Angus MacDonald, of Edinburgh, on 10th February. Dr. Flint is well known to our readers as the author of a Treatise on The Practice of Medicine.

## Books and Pamphlets.

**THE USE OF THE MICROSCOPE**, 2nd edition, by Dr. Carl Friedlaender, Privat-docent in Pathological Anatomy at Berlin. Translated by Henry C. Roe, M. D., M. R. C. S., L. R. C. P. (Lond.). New York : D. Appleton & Co. Toronto : Hart & Co.

The name of the author of this book is familiar to most English students, and we believe the present work will make it more so. Dr. Friedlaender has succeeded in presenting in a reasonably small compass all the important points as to microscopical examinations, conducted for

diagnostic and pathological purposes. He gives a concise statement of the processes employed in pathological histology, while the subject of examinations of Schizomycetes is treated exhaustively, which will, we are sure, be especially welcome to students at the present time. This edition contains a colored plate of the most important and characteristics chizomycetes. The book is printed as only Americans print books. The translator is to be congratulated upon the success with which he has done his work, as it reads not like a translation, but as though written originally in English. We are sure the work will be very acceptable, and useful to the large number of students now engaged in microscopy.

**A TREATISE ON THE DISEASES OF INFANCY AND CHILDHOOD**, by J. Lewis Smith, M. D., Prof. of Diseases of Children Bellevue Hospital Medical College, New York. 6th edition Philadelphia : Lea Bros. & Co.

The above work has been carefully revised, and some parts entirely re-written. This was rendered necessary, by the advancement of the knowledge of children's diseases, and their treatment. Since the issue of the last edition, croup, cerebro-spinal fever, scarlet fever and infantile diarrhoea have been entirely recast, and the treatment of the same thoroughly revised. The author has studied in successive editions to make the work more useful to the medical student, and to the physician in his daily practice, and the scope and character of the present volume, is evidence of the success which has attended his efforts. We heartily commend the work.

**A HANDBOOK ON THE DISEASES OF THE NERVOUS SYSTEM**, by James Ross, M. D., F. R. C. P., Senior Assistant Physician, Manchester Royal Infirmary, etc. Pp. 726, 184 illustrations. Philadelphia : Lea Bros. & Co.

This is a new volume on nervous diseases, and bears evidence of careful and thorough work on the part of the author. The work is divided into two parts,—general and special neurology. In the first part, the author gives a brief outline of the evolution and development of nervous structures and functions, and general principles of treatment. In the second or special part, is given with tolerable fulness the clinical features of the various diseases, and the means of differentiating between those which are clinically allied. The work is thoroughly practical, and will be found an excellent guide not only to the medical student,

but also to the medical practitioner, who wishes a comprehensive work on the subject.

**LECTURES ON SYPHILIS**, by C. Frank Lydston, M. D., Lecturer on Surgical Diseases of the Genito-Urinary organs, in the College of Physicians and Surgeons, Chicago, etc. etc., Pp. 176. Chicago : A. M. Wood & Co. Toronto : Hart & Co.

This is one of the best series of lectures on syphilis it has been our privilege to peruse. The author is evidently a high-class teacher, and presents his views in a most interesting manner. He has adopted the views of Otis, as the most logical and scientific which have yet been offered, in explanation of the pathological phenomena of the disease. The earlier chapters give a clear and comprehensive view of the pathology, which being read, leave a thorough understanding of the subject in the mind of the student. In the later chapters will be found a clear exposition of the treatment, with cautions as to the abuse of mercury. The book is well printed, and we can heartily recommend it to all who desire to get a plain and practical view of the subject, as taught by the most advanced pathologists and syphilographers of the present day, believing that it will prove more valuable to the student, than the larger and more comprehensive treatises usually read.

**TABULÆ ANATOMICÆ OSTEOLOGIÆ**. By Carl H. Von Klein, A.M., M.D., Dayton, Ohio. Cincinnati : Cincinnati Lithographic Co.

This is an anatomical hand atlas in Latin. The idea of the author is that the technology of medical science should be confined to one language. The engravings are excellent, and the work as a whole, one of great merit. We trust it will be appreciated by the profession, and such encouragement afforded the author as will enable him to complete the work. The present volume is devoted to osteology only.

**DISEASES OF WOMEN**, by Charles H. May, M. D., late House Physician to Mt. Sinai Hospital, New York, etc. etc., Philadelphia : Lea Bros. & Co. Toronto : Williamson & Co.

In this little work the author lays no claim to originality, but it will be found a careful compilation from the more extensive works of Thomas, Emmet, Mundé and others. It might well take the place of the student's notes, as all the contents as regards etiology, etc., are carefully tabulated. The book will be useful to students preparing for examinations, and to practitioners as a handy book of reference.

# THE CANADA LANCET.

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## Original Communications.

### FIBROID TUMORS REMOVED BY LAPAROTOMY AND ECRASEMENT—RECOVERY.

BY J. H. CARSTENS, M.D., DETROIT, MICH.,

Professor of Obstetrics and Clinical Gynecology, Detroit College of Medicine.

Every physician knows what is meant by fibroid tumors, although the name should probably be myo-fibroma, as it is composed of connective and muscular tissues, but I like the old name and shall say fibroid tumors. These tumors often cause great distress and even death, so that heroic means are often necessary to relieve the persons suffering from them. Two cases have lately come under my care which may be interesting to members of this society.

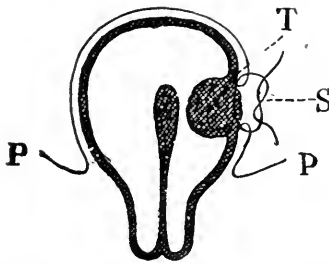
CASE I.—Mrs. C., seamstress: aged 40; has had no children, but a miscarriage ten years ago. Since then she has had more or less trouble. Menstruation painful and profuse. She first came to my office in September, 1884. Examination revealed an enlarged uterus, the cavity measuring four inches. Tumor in right iliac region, and very hard. No fluctuation could be detected. I diagnosed subperitoneal fibroid. I used ergot in various forms, as also tonics, but the tumor gradually increased in size; the pain and hemorrhage became more severe so that she insisted on an operation. As nothing could be gained by waiting, and she was failing fast, I sent her to Harper's Hospital. In the hospital a special room is kept for laparotomies which is in the attic, and isolated. This was thoroughly fumigated with sulphur and prepared for the reception of the patient. On June 15, 1885, the operation was performed. In the morning the patient had an antiseptic bath and the hair

of the pubes was shaved. Everything being in readiness at 10:30, a.m., the patient was put under the influence of chloroform by Dr. Gailey. I proceeded to operate, kindly assisted by Drs. Longyear, Johnson, Davendorf, Warner and Wean. All the physicians and nurses were required to wash their hands in a corrosive sublimate solution one in one thousand. The instruments were kept in carbolic acid water of two per cent. Steamed sponges were used, in short every possible antiseptic precaution was made use of except the spray. I told those present that I could not tell what operation I would perform. I might remove the ovaries, or the tumor. An incision was made in the linea alba, just above the pubes, and  $4\frac{1}{2}$  inches long, down to the peritoneum. When the hemorrhage was stopped, the peritoneum was incised on a grooved director to the same extent. The abdomen could now be explored, and I found that the tumor was imbedded in and surrounded by the right broad ligament. There was another smaller tumor at the anterior fundus of the uterus. The ovaries were adherent, as also the fallopian tubes. The observations of that distinguished English laparomist, Lawson Tait, go to prove that when the fallopian tubes are removed as well as the ovaries, the menopause is always established; but if the ovaries only are removed menstruation often does not cease. In this case I concluded to remove both tubes and ovaries, but as all were adherent I thought the patient would be subjected to less danger from secondary hemorrhage, septic poison, etc., if I enucleated the tumors, and closed the wound, by folding in the peritoneum and suturing it. I therefore made a longitudinal incision through the peritoneum down to the larger tumor, and then commenced to enucleate it. When I got to its attachment to the uterus the hemorrhage became profuse: I therefore applied a ligature to the pedicle. The tumor was cut off: all bleeding vessels ligated with silk: the peritoneum was folded in, and sewed together with interrupted sutures. The smaller tumor was then attacked by an incision and enucleated.

The wood cut will best illustrate the folding-in of the peritoneum. T the site of the tumor and S the sutures. The abdominal cavity was now thoroughly cleansed; the external opening closed by five deep and six superficial silk sutures and antiseptic gauze applied, the latter being held in

\*A paper read before the Canadian Med. Association, '85.

place by an abdominal bandage. About twenty vessels were ligated with silk, and cut short as was also the ligature of the pedicle. All the ligatures and sutures (of different sizes) were of Skene's silk, which was simply corded surgical silk, boiled for some hours in a mixture composed of carbolic and salicylic acid, each one drachm, and white wax one ounce. The patient re-acted well.  $\frac{1}{2}$  grain of morphine was given occasionally; catheter used every six hours; temperature taken every two hours. But I need not weary you with a long record of the same. The first few days she vomited often, which the ordinary remedies did not check. Bismuth, soda and carbonic acid water were all used without avail. On the fourth day she asked for lager beer, and as that is principally carbonic acid water containing a small quantity of alcohol and malt extract in solution, I could see no objection to its use, and allowed half an ounce every two hours. The first dose stopped the vomiting. The next day it was alternated and the dose increased to first one and then two ounces.



The stomach caused no more trouble after this. On the eighth day steak and potatoes allowed, as also eggs. On the next day the temperature went up to  $102\frac{1}{2}$ . It had always been about 100, rising to 103 on the 11th day. Two grains of quinine every two hours were ordered. A small abscess along the course of one of the deep abdominal sutures was the cause of the trouble. It broke on the 16th day and the temperature fell to normal. I now thought that the patient could soon be discharged, when she got a severe chill and pelvic cellulitis developed in the right side. Quinine was used freely, and iodine applied over the seat of the trouble. In the course of ten days the swelling and other symptoms gradually subsided, and five weeks after the operation the patient was discharged—cured. A few days later she was at her usual vocation, dressmaking, running a sewing machine, walking over a mile on a stretch, and so

on. The large tumor was  $4\frac{1}{2}$  inches in its long diameter and three inches in its short diameter. The small one was  $1\frac{1}{2}$  by one inch.

CASE II.—Mrs. S., aged 45; sterile; family history good; never was sick until eight years ago. She noticed that menstruation was profuse. This gradually increased until two years since, when she noticed an enlargement of the abdomen, and then consulted a physician who told her she had a tumor but should let it alone. The hemorrhage became more persistent, continuing for three months. Sometimes it would stop for a few days, and again last for weeks and months. When she consulted me she was very weak and anæmic. Examination revealed the os uteri dilated about one inch, and just within, a tumor could be felt like a child's head. It was a sub-mucous fibroid which had gradually been forced into the uterine cavity. The hemorrhage and severe labor-like pains required prompt attention, and I advised an operation. She consented, and on the 25th of August, assisted by Prof. Webber and Dr. Jones, of Leesville, I operated. She was put under the influence of chloroform, placed in Sims' position and a perineal retractor introduced. Efforts to dilate the os proved unavailing, and then with a pair of dull scissors I snipped the os towards the rectum; grasped the tumor with a vulsellum forceps, and was then able, after considerable work with a spoon saw, to apply the ecraseur and remove the growth, which was about four inches in its long and three inches in its short diameter. I then sewed the cervix with silk. I tried to use perforated shot, but found the latter not large enough to slip over the silk, and so had to make an ordinary knot. I generally use perforated shot to hold the sutures when operating for lacerated cervixes, fistulæ, etc., as follows:—I slip on the two ends of the sutures three to six perforated shots and compress the last one only. If I want to remove the sutures I have only to cut the suture between the last two shots, pull off the others and have the long suture to catch hold of and pull out. This plan facilitates the removal of the sutures which is sometimes troublesome. My patient rallied well and rapidly gained strength—she was able to sit up on the sixth day.

If I should draw any conclusions from these cases and my experience, in abdominal sections in general, I should say it is often impossible to decide

positively what operation is best to perform before the abdomen is opened. The operator should always be willing to modify or change the operation, and be prepared for all emergencies.

### BELLADONNA IN THE TREATMENT OF NOCTURNAL INCONTINENCE OF URINE.

BY H. AUBREY HUSBAND, M.B., C.M., B.S.C., UNIVERSITY OF EDINBURGH, F.R.C.S.E., ETC.

The frequency and difficulty experienced in the treatment of nocturnal incontinence of urine among children, and occasionally among young adults will be my excuse for publishing an account of the following case, occurring in a lad of nineteen years of age. The cause of this complaint is not always clear, for it has been ascribed to want of care on the part of the mother or those in charge of young children, to worms, to some affection of the bladder or urine, to fright, etc. Be the cause what it may the Draconian method of some parents of punishing their children either by repeated whippings or the deprivation of some harmless pleasure must be condemned without any reservation. The only effect of such a method of treatment that I have ever seen is to make the complaint worse. But as it is not my intention to enter into a discussion of the various methods of treatment, I shall content myself with the details of the case, which has called forth this paper:

T. B.—, æt. 19, the eldest of four sons, all of whom have been troubled with the same complaint from birth. The patient had, at various times, been treated with the tincture of belladonna, but with no apparent benefit, and it was only when it became necessary for him to leave home on business that a cure became a pressing need, and I was asked to do all I could for him. The patient is a fine healthy lad of a somewhat hasty, nervous temperament, which he inherits from his mother. There was no history of worms, but he suffered from chronic constipation, to relieve which the following pill was administered night and morning, and then only at night for some months:

R Ext. Aloes Barb. . . . gr. iii.  
 Ext. Nucis Vom. . . . gr. ½.  
 Gum. Mastiche . . . . gr. ½.  
 Fiat. pil.  
 Sumat unum nocte maneqe.

The lower bowel was washed out every night with an enema of warm soap and water, and then a suppository containing one grain of belladonna placed in the rectum. The object of the enema was to clear out any hardened feces or thread worms, which, by their presence, might by their irritation produce the incontinence. This treatment was rigidly continued for three months with some slight benefit, a week or two passing without a return of the complaint. The amount of belladonna was now increased to a grain and a half. And then a new symptom made its appearance. The nocturnal incontinence ceased, but the patient during the day became troubled with a constant desire to pass water, the annoyance was so great that he had to micturate every five minutes. The suppository was then ordered to be used night and morning, with the entire discontinuance of the nocturnal and diurnal trouble. During the last three months the pupils became permanently dilated, but there was no irritation of the skin, and only occasionally slight dryness of the throat. In six months a complaint which had lasted nineteen years was completely cured, and the patient was enabled to proceed to the continent on his business, taking with him a mixture containing nitromuriatic acid, strychnia and gentian. The conclusions I have drawn from the above case are these, that of all preparations of belladonna the extract is the best, that the success in treatment, to a great extent, depends on the clearing of the rectum of its contents, and the application of the belladonna as near the bladder as possible, and that partial success at first is no reason to discontinue the treatment in despair. The case is interesting, as occurring in a family of four boys all affected with the same complaint, and from the fact that the second son, who formed a clandestine marriage at 16, was cured without treatment of any kind.

### Correspondence.

To the Editor of the CANADA LANCET.

SIR,—I saw an article in the March number of the LANCET contributed by my friend, Dr. Dewar, on his experience with peritonitis.

I, too, have had what seems to me to be an unusual experience with it. I have had 16 cases within a radius of five miles in the last three months. I have had two deaths, both within



twenty-six hours from the onset of the pain. I held a post-mortem on one, a man of 34, and found perforation of the Vermiform Appendix due to the presence of an orange or lemon seed. I was not allowed to hold a p. m. on the other, a young man of 25, but from the history I concluded he had ruptured a blood vessel. He had done some very heavy lifting for two days before he was taken ill, and after his death over a gallon of apparently pure blood poured from his mouth.

I could not trace any cause for the disease in any of the other 14 cases. They were not limited to any particular class, age or sex. They rated as follows:—3 cases, women over 60 years; 4 cases, men between 55 and 72 years; 2 cases, married women aged 25 years; 1 unmarried woman, aged 22 years; 1 boy, aged 14 years; 5 cases were from 19 to 31 years of age.

None of the cases I had suffered from epistaxis. One, the young woman, had pleurisy on the right side at the same time. The cases I had, evidently differed from those described by Dr. Dewar, (fortunately for me) as, though some lingered, in every case they improved from the time the system became fully under the influence of opium.

Yours, etc.,

Morpeth, Ont., March 23, '86. A. M. SHAVER.

### Reports of Societies.

#### MEDICO-CHIURGICAL SOCIETY OF MONTREAL.

Regular meeting, 19th March, President in the chair.

Dr. Roddick shewed a case of excision of the elbow joint, where he removed the articular surfaces of the radius, ulna and humerus. The result was quite successful, as the man was acquiring strength and use of the arm. Dr. R. also exhibited for Dr. Bryson, of Port Arthur, a so-called sarcomatous tumor of the testicle; also, two tuberculous testicles, one of which he had removed to day.

Dr. Gardner exhibited a uterine fibroid and uterus removed by the clamp after the manner of Dr. Keith, of Edinburgh. The case is doing well.

Dr. Trenholme said that this case was well suited for the V shaped operation as devised by himself, and carried out with success upon several occa-

sions. The tumor was small, uniform, and the neck distinctly discernible.

Dr. T. J. Alloway gave a report of a case of "Alexander's" operation, where he found great difficulty in finding the round ligament, but being assisted by Dr. Roddick and Gardner, the cord was secured and the operation completed. As the case occurred in a child-bearing woman, and the uterus could be easily replaced in position, Dr. Kingston, Kennedy and Smith questioned the expediency of the operation. The effect of the operation upon those who became pregnant was yet to be seen.

Dr. Trenholme said that Alexander's operation, though sometime before the profession, had not yet obtained an unquestioned place in gynecological surgery. There is still doubt as to the particular class of cases in which it may reasonably be expected to be useful. Further study is needed as to the anatomy of the round ligament. This line of investigation could be helped forward by those who have charge of the dissecting room. If the ligament is frequently found to be imperfectly developed, we will then have to see in what class of cases this anomaly exists, for upon this fact will depend the election of cases. It is with this end in view that I now give the details of a case lately under my care. The history of the case is as follows:—The young lady is 26 years of age, slight build, but regularly and symmetrically developed, from earliest appearance of the menses has been a sufferer. There are severe pains preceding and following the menstrual flow. Her sufferings are so severe that she is obliged to lie in bed and take sedatives, or have hot fomentations for their relief. The menstrual pains are gradually increasing in severity and duration, so that now they last for 6 or 7 days. During the flow, and for about a week before the premonitory symptoms of the flow, she enjoys comparative comfort. Upon examination the uterus is found retroverted, the fundus is well down into the hollow of the sacrum. The left ovary is dislocated and occupies the pouch of Douglas, it is tender and slightly enlarged. The left fallopian tube and right ovary are normal, but the right fallopian tube is enlarged, probably due to chronic inflammation. The uterus is easily replaced, but the prolapsed ovary on the left side, and the diseased tube on the right side, renders the retention of any form of support, a difficult matter. There are no indications of thickening of

the tissues from pelvic cellulitis. Under these circumstances I proposed Alexander's operation as a substitute for the more serious one of removal of the ovaries and tubes. The operation was undertaken, when I found the left round ligament so extremely attenuated that it afforded no hope of a successful result, and consequently the operation was abandoned. The vein accompanying the cord was very much congested, which I regard as indicating serious congestion of the pelvic viscera. Now, in this case I have no doubt but that this congenital defect of the round ligaments is responsible for all the displacements and suffering of my little patient. I might add that, withdrawing the cord to the extent of two inches, gave no control of the uterus; whether this was due to a superfluous extent of cord, or some internal adhesions I do not know. This case has been an instructive one to me. From it I would gather, that the cases most likely to be benefited by this operation are those of acquired luxations in those who have ceased bearing children, and where we have reasonable ground to expect a normal development of the round ligament. I submit this case as a small contribution to the literature of this subject, in the hope that other and abler observers may pursue the investigation, and define, with approximate certainty, the class of cases in which it should be performed.

### Selected Articles.

#### CHIENE'S CONTRIBUTIONS TO PRACTICAL SURGERY.

1. When the surgeon is called to a scalp-wound, he has first to satisfy himself as regards its depth. If it does not implicate the pericranium, it may be looked upon as a comparatively trivial accident; but if the pericranium is torn, the bone is exposed, and the probability is that the blow has been a severe one, and that the bone is more or less bruised. To discover the exact condition of the wound, the finger is the best probe, and the finger-nail passed over the exposed bone is the best guide to the exact condition of the bone. The probe is not nearly so certain an instrument in diagnosing the presence of a fissure. When the pericranium is torn and the bone bruised, the injury to the soft parts is of minor importance; the injury to the bone and its pericranial covering is of special importance. In such a case the application of a pad of dry lint, fixed in position by a roller bandage,

may result in rapid union; but after such treatment, every now and then disastrous results followed. The rule now is in scalp wounds thoroughly to purify the wound with a 1 to 20 solution of carbolic acid, using, if need be, in cases in which the wound is ingrained with dirt, a nail-brush, by the free use of which a thorough purification can be effected. Any bleeding vessels are secured by ligature; a cat-gut drain is laid along the wound to ensure free drainage, and the edges of the wound are brought together with horse-hair stitches. In the hairy scalp it is necessary to shave the edges of the wound. A piece of protective, covering not only the wound, but the extremities of the cat-gut drain, is applied: then a pad of gauze, the deeper layers of which have been damped with the lotion, or a pad of salicylic wool or Hartmann's wood wool which is impregnated with corrosive sublimate. This must be carefully fixed in position with a bandage, and care must be taken to apply this bandage in such a way that it will not come off, viz., by carrying the bandage round the head under the occipital protuberance above the eyebrows and under the chin, so as to make a complete cap. To ensure the stability of the bandage, it is safest to use a darning needle and darning cotton, with which the edges of the bandage may be carefully stitched together. This dressing, as a rule, may be left on for a week or ten days, when it is removed, and the wound is found dry. The horse-hair stitches can then be removed.

A severe scalp-wound is sometimes complicated with fissured fracture of the vault of the cranium, and, as has been said already, the finger-nail is the best means of diagnosing a fissure. In such cases the treatment is the same as in scalp-wounds without fracture. In a fissured fracture of the base of the cranium, implicating the petrous portion of the temporal bone, the middle ear, and the membrana tympani, the external meatus should be carefully washed out with 1 to 20 carbolic lotion, and the ear stuffed with carbolic gauze. It is in reality a compound fissured fracture, and should be treated with careful antiseptic precautions. Depressed fractures of the cranium are either simple or compound. In simple depressed fracture the surgeon should not trephine until there are well-marked symptoms of compression. In compound depressed fracture there is a tendency in the present day to wait for symptoms before elevating the depressed fragments. For my own part, I am of opinion that the elevation of the depressed fragments does not in itself increase the danger. If the surgeon waits until symptoms have appeared, the accompanying inflammation of the membranes cannot with any certainty be checked by the elevation of the fragments; and therefore I am of opinion that in the adult, at any rate, the fragments should be elevated without delay. In children the resiliency of the bones is such that, in uncomplicated cases of com-

pound depressed fracture, the surgeon may wait for symptoms; but even in them, in a severe case, it would be well to elevate the fragments at once. In punctured fractures, which are always compound, all are agreed that trephining should be performed at once, because the sharp splinters of the dense inner table will sooner or later cause inflammation of the membranes of the brain.

The experimental researches of Hitzig and Ferrier into the localization of the motor areas grouped around the fissure of Rolando have increased the interest of those injuries to the practical surgeon; and it is of great importance that a careful record of the symptoms in all cases of injury in that region should be kept. In order to do this with facility, the surgeon must be able to localize the exact situation of the fissure of Rolando. Various rules are laid down for this purpose. In the writer's opinion, one of the simplest methods is that described by Mr. A. W. Hare (*Med. Abs.*, p. 51. 1884). As the result of his observations, Mr. Hare found that "the distance from the glabella to the fissure (of Rolando) was on the average 55.7% of the distance from the glabella to the external occipital protuberance." The "general direction of the fissure" was ascertained by "noting the angle which its axis, as represented by the line between its extremities, forms with the mesial line of the head." The average angle in the 11 cases examined was found to be 67°.

2. The tumor of the scalp of most common occurrence is the wen, a thick walled cyst containing sebaceous matter. It is unnecessary in the removal of a wen to cut away the hair over it. All that is required is to make a linear parting with a comb over the tumor, and the tumor is then transfixed with a sharp pointed curved bistoury, the incision being directed towards the vertex, to avoid injury to the bloodvessels. The most superficial part of the cyst wall is often friable; and as it is of importance to remove the cyst wall entirely, the dissecting forceps with which the cyst wall is grasped must not be applied to the superficial friable portion; but one blade of the forceps should be pushed under the cyst at one extremity of the incision, the other blade grasping the inner surface of the cyst, and then, with a quick jerk, the whole cyst is removed without any laceration.

Thin-walled cysts are frequently met with about the eyebrows. These cysts require to be dissected out, and if any portion of the cyst wall is left, they are apt to return. In the dissection of these thin-walled cysts the wall is very apt to give way, the contents escape, and the cyst collapse; and if an attempt is made to finish the dissection in the collapsed condition, portions of the cyst wall may be left. The difficulty is overcome in a very simple way. If the cyst bursts during the dis-

section, squeeze out the contents, and stuff the cavity completely with a strip of lint, so as practically to change the cyst into a solid tumor; and if this is done, the dissection can be completed without difficulty.

3. In old people soft warty growths are often met with on the face. It is dangerous to apply irritating caustic substances to these growths, because if they are irritated they are apt to take on an epitheliomatous action. They are best treated by excision.

4. As the result of cold, acute inflammations sometimes occur in the parotid and submaxillary regions under the strong fascia. Unless tension is relieved by the timely application of leeches or by incision in these cases, suppuration is apt to occur under the fascia. If the incision is made entirely with the knife, important structures may be divided; and in these situations, as well as in deep-seated inflammations below the sterno-mastoid muscle, in the posterior triangle of the neck, and in the axilla, Hilton's method should always be adopted. A short incision is made through the skin and subcutaneous tissue, and a grooved director is then insinuated through the fascia into the inflammatory area. If no pus appears, then the director is withdrawn; and the hæmorrhage which results from the puncture, and the escape of the serous effusion through the opening of the fascia, may be followed by the subsidence of the inflammation. If pus appears along the groove in the director, then a pair of dressing forceps is passed along the groove into the abscess; the director is withdrawn, the forceps remaining in position; the forceps are then opened and withdrawn, with their blades apart, in order to enlarge the opening in the fascia, allowing of the free escape of the pus and the introduction of a drainage-tube. Thus all deep-seated suppurations can be opened without risk.

5. In the removal of epitheliomatous tumors affecting the lower lip, the subcutaneous injection of a 4% solution of cocaine into the tissues surrounding the tumour enables the surgeon to remove the mass without pain. This drug can also be used in a similar manner in the removal of an epitheliomatous nodule from the tongue.

6. In strumous enlargement of the glands of the neck, cicatricial deformity is common, which necessarily occurs if the suppurating masses are allowed to open of themselves, or if they are simply opened when pointing takes place. The best way to treat such cases is either to excise the enlarged glands in the early stages of the disease, before they have become matted to the surrounding tissues by inflammation; or in the latter stages of the disease, when suppuration has occurred, the sharp spoon must be freely used, in order to remove entirely the degenerating gland tissue. Rapid healing and less deformity is the result. The danger also

of secondary mischief in the lungs and elsewhere is in this way minimized. Tumors of the neck occurring under the sterno-mastoid muscles are divided into simple and malignant growths. If simple in character, they may be removed, however large they may be, with comparative safety. The great points to be attended to are—free access to the growth, and a dissection down to the tumor. If malignant, they should, as a rule, be left alone.

7. The removal of foreign bodies from the nasal cavity is best effected by the use of a small scoop. The foreign body is best seen by the aid of reflected light from a laryngoscopic mirror. The scoop is introduced horizontally above and beyond the foreign body. The handle of the instrument is then elevated, tilting the foreign body out through the anterior opening. The sensitiveness of the mucous membrane of the nose is greatly diminished by painting the parts with a solution of cocaine.

8. In the treatment of ranula by grasping the cyst wall with a pair of catch-forceps, and removing an elliptical portion with curved scissors, the wound is apt to heal too rapidly before the cyst contracts, and a reaccumulation of the glairy fluid is apt to occur. By seeing the patient daily for a week, in order too introduce a probe into the incision, too rapid healing is prevented.

9. It is not always easy to make a diagnosis between syphilitic diseases and epithelioma of the tongue. Syphilitic disease is generally central, an epithelioma lateral. Iod. pot. is used to clear up the diagnosis. Care must be taken not to be deceived by a temporary improvement, because this occurs in epithelioma by persistent use of the iodide.

10. In acute tonsillar inflammations in which suppuration is suspected, a Græfe's knife is the best instrument with which to make the diagnostic puncture. This instrument is of the greatest use in all cases of suspected suppuration. After the knife is introduced into the inflammatory area, it is rotated, and if pus is present it escapes at the side of the knife. The incision can then be enlarged, so as to allow of the free escape of matter. If there is no pus present, the knife can be withdrawn. In the case of the inflamed tonsil, the puncture may be repeated at two or three different points, and the resulting hæmorrhage often relieves the inflammation. The knife should always be pushed directly backward, to avoid any risk of wounding the internal carotid trunk. In a large proportion of cases of inflamed tonsil the suppuration occurs at the upper extremity of the tonsil, and the matter can only be properly reached by introducing the knife through the soft palate. Any fulness and inflammatory redness of the palate is an indication for a puncture in this situation. The removal of a portion of a chronically enlarged tonsil should not be performed when

there is any acute inflammation present. In performing this operation on the adult, the tonsil should be grasped with a vulsellum, and the projecting portion removed, the surgeon cutting from above downwards in a vertical direction with a probe-pointed bistoury. To avoid injury to the dorsum of the tongue, a piece of lint should be wrapped round the blade of the knife, so as to cover that half of the cutting edge which is nearest the handle. The probe-pointed knife used should cut to the point, and must be very sharp, in order that the operation may be done satisfactorily.

11. In opening a retropharyngeal abscess, the operation cannot be performed with antiseptic precautions if the abscess is opened from the mouth; and in those cases in which there is any suspicion of disease of the vertebrae, the abscess should be opened by Hilton's method, the matter being reached through an incision along the posterior border of the sterno-mastoid muscle, an inch below the apex of the mastoid process of the temporal bone.

12. When a surgeon is called in a hurry to a case of choking, he should not delay in order to obtain œsophageal forceps or probangs, because, if the foreign body has reached the œsophagus, the immediate risk to the patient's life has passed away. If death is imminent, then the foreign body, generally a piece of meat, is in the pharynx and blocking up the rima glottidis, or it has passed into the box of the larynx. If in the first situation, it can be displaced by the finger. If in the second situation, the operation of laryngotomy is called for.

When the obstruction is complete, there is no time to perform the more difficult operation of tracheotomy. If the foreign body has reached the œsophagus, if it is a piece of meat or a piece of bread, or any digestible substance, the simplest way to get rid of it is to push it onwards into the stomach with a probang. If, however, it is a metallic substance, it should, if possible, be removed by the mouth. Before attempting removal, the first point to clear up is its exact situation. This is best done by passing a bulbous-shaped bougie. The bulbous head, measuring about half an inch in transverse diameter, should be made of solid metal, giving the instrument a certain weight. The stem of the instrument should be of whalebone, about the size of a No. 8 catheter. If this instrument is passed along the œsophagus, the foreign body may be felt as the instrument is passed downwards. In some cases, however, the obstructing substance will be best localized as the instrument is being withdrawn, and in the withdrawal of the instrument the foreign body may be brought along with it. Should this not take place an endeavor must be made to grasp the foreign body with forceps. If the metallic substance cannot be removed by the mouth, the operation of œsophagotomy must be performed.

If the foreign body has passed into the trachea, the operation of tracheotomy should be performed before inverting the patient. There is a risk in inverting the patient before performing tracheotomy, because a substance may stick in the box of the larynx and choke the patient. If this occurred, then tracheotomy would be called for, and in the hurry could not be properly performed.

13. *Hare lip.* This congenital deformity may be single or it may be double. If double, the premaxillary central projection may, if of any size, after partially dividing its base, be displaced backwards, and utilized to fill up the gap between the superior maxillary bones. As a rule, however, if it is rudimentary, after dissecting off the triangular portion of skin upon its surface, it may be removed. In doing this the hemorrhage is often profuse, and must be checked by pressure before proceeding with the operation. The malformed upper lip is often tacked down to the maxillary bones, and the mucous membrane must be freely divided so as to allow the edges to come into easy apposition. The edges are to be freely pared, and care is to be taken to avoid a cleft at their point of junction at the edge of the lip.

14. *Tracheotomy.* This operation is called for in cases of laryngeal difficulty of breathing. The trachea is nearest to the surface at its upper part, and the high operation above the isthmus of the thyroid is more easily performed than the low operation below the isthmus of the thyroid. The deep veins are comparatively unimportant above the isthmus, while below the isthmus the inferior thyroid veins are of large size. Care must be taken in the administration of chloroform that the patient be not deeply narcotized, in order that he may be able after the trachea has been opened to cough up the blood which may pass through the tracheal wound into the trachea. In performing the operation the knife should be used until the sterno-hyoid and sterno-thyroid muscles have been separated. When this stage is reached, the upper tracheal rings should be cleared with the director, the best for this purpose being Spence's hernia director. If this director is used, the risk of wounding the deep veins lying on the trachea is lessened. If these veins are wounded they should be ligatured, and all bleeding should have ceased before the trachea is opened. No attempt should be made to open the trachea until the upper rings above the isthmus are fully exposed. The tracheal rings are best divided with a sharp-pointed curved bistoury. A sharp hook is passed into the substance of the cricoid cartilage; and, the back of the knife resting upon the finger-nail, the knife is pushed into the trachea, and the surgeon cuts the uppermost rings between the isthmus and the cricoid cartilage. The handle of the knife is introduced into the slit thus made, and is then turned transversely, so as to separate the edges of

the tracheal incision. The tracheal tube is then introduced. At first the tube is held at right angles to the long axis of the tracheal wound, until the extremity, of the tube is fairly within the tracheal cut, when the long axis of the tube is carried to the middle line, and the tube is pushed onwards into the trachea.

The primary object of the operation is to relieve the laryngeal obstruction, and to allow air to reach the lungs. The operation, however, has a secondary value—the inflamed larynx is rested. After this operation the patient may die either of the disease for which the operation has been performed, or he may die from blood which has passed into the trachea during the operation reaching the ultimate bronchi, and giving rise there to septic lobular pneumonia. Hence the importance of preventing as much as possible any blood from passing into the trachea during the operation.

21. In severe cases of suicidal cut throat, a transverse direction of the wound causes great gaping of the edges. The wound is generally close above the box of the larynx, or it may be through the thyroid cartilage. As a general rule, the safest thing for a patient is to perform tracheotomy immediately, and carefully stitch together with catgut the different structures which form the sides of the gap, but the skin and subcutaneous tissues with deep stitches of double horsehair. Prevent tension on these stitches by keeping the head well forward, and introduce a drainage-tube at either corner of the wound. The depressed condition of the patient, and the risk of a persistence of the suicidal tendency, require that he should never be left without an attendant. He must get plenty of nourishment. This is best administered through a large-sized catheter introduced through the mouth or nose, past the wound, into the upper part of the oesophagus.—*Edin. Med. Jour.*, Dec., 1885.

#### SUTHERLAND ON THE PREMONITORY SYMPTOMS OF INSANITY.

It will be my object, in the time I have at my disposal, to describe as briefly as possible the most important premonitory symptoms of insanity, and to conclude by making a few remarks upon their treatment.

Esquirol recognized three distinct stages of insanity. In the first, there is a change of habits; in the second, perversion of the affections; and the third constitutes true insanity. The first set are usually seen only by the relatives of the patient; the second, by the family-physician; and the third, by the asylum-superintendent, when they are now so far advanced that any attempt at prophylactic treatment is out of the question.

It is almost impossible to say from the premonitory symptoms what form the insanity will assume,

unless, indeed, the patients have suffered from a previous attack. Almost all authors agree, however, that insanity rarely commences with excitement. As an exception, may be mentioned the mania which is produced suddenly, after a moderate amount of alcohol, in a person who has previously sustained an injury to the head, or has had a sunstroke. But the majority of cases are preceded by a stage of depression, which has been called by Guislain the "stadium melancholicum."

To estimate the duration of these premonitory symptoms is, as a rule, impossible, as the relations of the patient, either from deficiency of experience or from a wilful perversion of the truth, only throw obstacles in the way of the practitioner, who is trying his best to get at the real etiology of the case.

From a long experience of such matters, I have no hesitation in saying that, in my opinion, some eccentric act on the part of the patient, done many years before the actual outbreak of the mental disease, can be detected in the majority of cases, if the early history of the patient be only carefully investigated.

Irritability and a tendency to take offence are very common at this stage, sometimes accompanied by moroseness and silence, or again by noisy scolding and fault-finding with servants. There may be an indifference to usual employments, or, on the other hand, a restless pursuit of novel occupations. Delusions of suspicion and jealousy are now developed against those with whom the patient has always lived on good terms. And it must be remembered, in sifting evidence, that there are occasionally good grounds for these delusions.

Sometimes the patient thinks he is ruined, and again he may launch out into endless extravagance, giving orders for carriages and horses which he will never be able to pay for.

Loss of memory is also a very marked symptom. A patient will remain seated in your consulting room much longer than is necessary, and long after you believe the interview is concluded. He will get up in the night, and think it is the morning. He will take three or four hours to dress, owing to his performing parts of the toilet more than once, and forgetting that he has done so. He will eat voraciously, or he will neglect to take his food, simply from loss of memory.

The mental and the bodily symptoms now begin to act and to re-act upon one another. Through forgetfulness, the patient neglects to take exercise, and to attend to his bowels, and through the stagnation and constipation thus produced an increased feeling of malaise and depression comes over him. A general neglect of personal appearance will not escape the eye of the expert practitioner. The expression of the face is also strangely altered, the lines of the features becoming more marked in melancholia, but obliterated and dim in epileptic cases. In acute hysterical mania, and in puer-

peral insanity, the cornea becomes bright, prominent, and staring. But, on the contrary, in mas-turbating insanity, the patient seldom looks you in the face, and, when he does so, there is an absence of that expression of the sympathetic eye of De Quincey, which is so eloquently characteristic of a healthy mind. A row of paupers at work on a road can thus be distinguished from a gang of lunatics. In the one case they will all "catch your eye," as you drive past: in the other case they will not.

A word as to bodily symptoms. The posture, and even the gait, of an insane person is abnormal. The skin, as a rule, is harsh and dry, although sometimes perspiring. It emits, in some cases, a peculiar odor, although this has been denied by the highest authorities. Occasionally rigors, feverish heat of skin, and elevation of temperature, are noticed, which, however, are usually due to some accompanying somatic condition, the cuticle being, as a rule, dry or clammy. The tongue is usually white and coated, and the breath offensive, from refusal of food and neglect of the bowels, which are, at this stage, almost invariably confined. The appetite is generally deficient from want of fresh air and exercise, and from constipation. The circulation is commonly feeble at first. The pulse is either slow (50 to 60) or too rapid (120), in delirious cases.

Generally speaking, the face is pale, but in very rare cases there is great congestion of the head, heat of the scalp, and throbbing of the carotid and temporal arteries. Headache is a very common symptom. This is produced partly by the changes, functional or organic, which are going on in the brain and its membranes, partly by the presence of an excess of bile in the system, due to the neglect of his health on the part of the patient, and also from a condition either of plethora or of anæmia, local or general, in the head and whole system.

Sexual appetite is in abeyance in some cases, as in those of bilious melancholia. It is in excess in others, as in those of general paralysis, and, oddly enough, is conspicuously so in senile dementia. The maid-servant is frequently found to be pregnant by the master, before any mental aberration is discovered by the relations, in this form of mental disorder.

The catamenia are frequently suppressed, although many attacks occur and run their course without any abnormality being observed in this function.

Impairment of some of the special senses, real or imaginary, is sometimes noticed. Deafness is occasionally simulated. Real abnormal sensations of heat and cold, of pricking and electrical shocks, of attempts to shake the bed of the patient, and of irritation, referred to the ends of the fingers and toes, are also frequently noticed.

The voice of the patient is almost always altered, becoming low and almost inaudible in the stadium melancholicum, but high in pitch, should mania be developed. Sometimes the patient talks more rapidly, sometimes more slowly and deliberately, than usual. Sometimes he will raise his voice and shout; in other cases, he will speak only in a whisper, or not at all.

Articulation is rarely affected, excepting in general paralysis. The style of conversation is, however, often changed, oaths and obscene language being uttered by those who were never previously known to be guilty of such conduct. Muttering and talking aloud to the patient's self is frequently noticed.

Not unfrequently the patient will roam about the house, or wander away from home on an objectless journey. One patient, now in my asylum, walked barefooted from London to Portsmouth, before admission, under some religious delusion.

Delusions, illusions, and hallucinations are, however, comparatively rare during the premonitory stage. When they are developed the disease may, as a rule, be pronounced as being insanity, and all prophylactic treatment is now useless. The ship must go before the wind, and you must steer it, as best you can, through the tempestuous course which will lead to recovery, to death, or to hopeless dementia.

A word, if I am not trespassing too long on your valuable time, as to treatment prophylactic, medical, moral, and hygienic.

1. *Prophylactic.* If a patient has been known to have an attack regularly every year, which is not uncommon, send him for a trip with an expert and agreeable medical man, a month before the time of the onset of the mental disorder is expected. This frequently not only staves off one attack, but sometimes even prevents an accession of future attacks. But if the slightest premonitory symptom should exist, keep him at home, as he must undoubtedly undergo the course of the disorder, and it is extremely dangerous that he should do so, if far away from good medical advice.

2. *Medical.* Bromide of potassium, or chloral, or belladonna, may be used where there is heat of head or sexual excitement. Opium and morphia in anæmic cases. Judge by the condition of the pupil whether opium or belladonna be indicated. Antimony is the sheet-anchor in violent cases. Do not add digitalis. Calabar bean is indicated in the early stages of general paralysis. Iodide of potassium and mercury often allay excitement, when the mental symptoms are due to some syphilitic taint.

Hydrocyanic acid, with or without the bromides, is useful in robust cases of mania.

Henbane, in my hands, has proved a disappointing remedy. It is feeble as a sedative, and only valuable as such in large doses, such as half an

ounce of the tincture; and even in small doses it often produces headache.

Combinations of drugs are invaluable, such as chloral with bromide of potassium, chloral with the liquor morphiae bimeconatis, bromide with cannabis Indica, in acute mania; bromide with ergot in recurrent insanity; morphia with assafoetida in hysteria.

Conium is useful where there is much motility; quinine in intermittent insanity; and sumbul or chloral in the status epilepticus.

Aperients are almost always required in the early stages. The milder purges are, as a rule, indicated. These are: Æsculap and Hunyadi János waters; granular effervescing citrate of magnesia; stewed prunes, oranges, and similar domestic remedies. In extreme cases, enemata are necessary, which must sometimes be administered daily, and, if there be no obstruction, croton-oil. Avoid pills, as the patient, if suicidal, will hoard them up, and then take a poisonous quantity.

Should medicine be refused, a subcutaneous injection is occasionally useful, but I prefer disguising my remedies. Chloral in beer or port-wine, tincture of opium in coffee, antimony in any liquid (as it is tasteless); and, as regards aperients, calomel between thin slices of bread and butter; syrup of senna in a cup of tea, in lieu of sugar; and other similar harmless modes of deception are now allowable.

3. The *moral treatment* must consist of a mixture of kindness and firmness; and, above all things, we must remember that each case requires different treatment.

4. The *hygienic treatment* is obvious. Let the patient walk out daily till he nearly drops from fatigue, and soon all complaints of loss of sleep and want of appetite will cease; and, although the disease may yet have to run its course, the symptoms will be milder, and the outlook more hopeful, than would have been the case if the patient had been allowed to have his own way.

I must apologize for the concentrated form in which I have been obliged to put these remarks. Let us not think that, by treating the premonitory symptoms of insanity, medical men will want for work. As long as human nature, sexual intercourse, and alcohol exist, so long will there be excess; and, in consequence, plenty of work for our profession—whether we endeavor to sound a note of warning to the foolish, or to alleviate the distress of those who now undeservedly suffer for the sins of their forefathers.—*Br. Med. Jr.*, Jan. 30, 1886.

## THE DRY METHOD OF TREATMENT IN UTERINE DISEASE.

Dr. Engelmann said that this was to be merely a preliminary paper, as he had not yet fully per-



fecting this method of treatment and was not quite ready to place it in full before the profession, but as the same innovation was often in the minds of several, he wished to make the announcement before the society and claim this method which he had gradually evolved, as his own. As a method, in its outlines, it was satisfactory and practically complete—yet he felt that he had not yet reached all he wished to attain until he had succeeded in devising a sensible method of applying impalpable powders to the uterine mucosa and evenly distributing them over the surface of the membrane. The dry treatment with powders and medicated cotton, acting upon the uterus, the body of the organ, and the surrounding tissues, was the leading feature of his method of treatment.

Dr. Engelmann reviewed the various methods of treatment customary in different countries, and characterized America as the land of nitrate of silver and iodine; the former, once most popular, now gradually yielding to the latter. He had long since given up as injurious, rather than useless, the use of strong intra-uterine applications, generally speaking of course, as in certain cases they were needful, and the only proper remedy; he severely criticised the very common custom of mopping the uterine cavity with strong solutions, especially the altogether too common and indiscriminate use of nitrate of silver and iodine, to which since the days of carbolic acid, iodized phenol had been added—the three fluids, which, in this country generally make up the armamentarium in the treatment of uterine disease.

Dr. Engelmann had at first naturally followed the practice of those about him, but soon gave up the indiscriminate use of strong fluids, using weak solutions, or dilute fluids. Since 1873 he has endeavored to replace fluids, whenever possible, by powders, at first trying tannin, iron, nitrate of silver (in small proportions) in bacilli, but the preparation was expensive and unsatisfactory; nor did Mitchell's gelatine pencils quite answer, but last spring Mr. Mitchell, of Philadelphia, prepared a very delicate gelatine pencil, which answers better than anything yet made for the purpose of intra-uterine treatment. So also the iodoform pencils of Parke, Davis & Co. are very serviceable.

These he uses in case he deems it necessary to treat the mucosa directly, in certain cases, however, resorting to fluids. In the majority of cases he relies on medication applied to the cervix by means of cotton and the powder blower. He deems it wrong to treat a diseased uterus through its smallest and most delicate part, the mucosa, but would rather rely on treating that sensitive membrane through the uterus, hence the use of powders and medicated cotton.

Dr. E. mainly uses iodoform, borax, bismuth, oxide of zinc, alum, tannin, calomel, and sulphate of zinc, which are dusted over the cervix and

vaginal walls. Iodized, carbolized, borated, tannated, salicylated and iron cotton, and corrosive sublimate, jute he considers the most delicate means of applying a remedy, as it is kept in contact with the parts, until gradually absorbed; the cotton at the same time, must be judiciously placed, so as to rectify such malposition as almost always exists more or less in a diseased uterus.

This method is a most happy combination, as it combines the best and least irritating way of ameliorating displacement with a delicate and effective method of treating the co-existing pathological condition. Moreover, a support, such as is afforded by the properly placed cotton or jute tampon, is an aid of treatment and a relief to the patient, in morbid conditions not directly complicated with displacement: the sensitive afflicted parts are supported; a strain is removed.

The glycerine tampon, once so popular, Dr. E. uses but little, but admits that under certain distinctly marked conditions, it renders admirable service; but even there it is not necessary, other means can be substituted, and he prefers them to this filthy remedy.

The dry method, the treatment of the uterine mucosa through the muscular and surrounding cellular tissue has beyond the advantage of greater certainty, that of comfort and cleanliness; it is not painful, the patient does not suffer in the office, is not in agony during the treatment, nor does she go home to be reminded of her suffering by hours and hours of cramps and pain. She leaves the office comforted, feeling better.

Dr. E. does not cast aside intra-uterine applications, but claims that they should no longer be resorted to as a routine method of treatment, and when called for, should usually be of milder character than now commonly applied.

Many a victim to pessaries will be spared when the dry powder and cotton treatment is adopted, as the gradual replacing of the diseased organ is far better accomplished by medicated tampons, whilst the morbid condition is at the same time done away with, than by the irritating and dangerous pessary. Not that the doctor desires to interfere with the pessary in its proper place as a support to the movable and healthy, but displaced uterus.

The pessary, the intra-uterine application, the glycerine tampon, all find certain indications, but have done great harm by the indiscriminate abuse to which they have been put. More generally serviceable, more reliable as a method of treatment, and less dangerous is the dry method, the treatment of the entire organ, or the mucosa through the corpus and cervix with powders and medicated cotton. Dr. E. soon hopes to devise a method of successfully distributing impalpable powders over the surface of the mucosa, and will then consider his method complete.

Such gentlemen as have witnessed Dr. E.'s treatment have never failed to appreciate its advantages, and the powder blower, which could not be obtained in the city previous to its use by Dr. E., is now to be had at most of the instrument makers.

Dr. E. has already demonstrated the advantages of this method in his department of the "Polyclinic" and cited a number of cases of disease of the mucosa with profuse discharge, previously treated by others by the intra-uterine method, which had been treated in the "Polyclinic" exclusively by the dry method, with the most rapid and surprising results, and promised soon to publish a number of case histories, carefully kept by the staff, which will demonstrate more clearly the method and its advantage.

Dr. E. closed his remarks with the wish that his colleagues would test the method which he had found so efficacious. The doctor was aware that dry cotton and powders had been used of old, but never in such combination and as the mainstay of the gynecologist, and no such method had ever been advocated or published; hence he lays claim to this method at the perfection of which he has so long labored, and claims it as his own. — *Am. Med. Digest.*

#### FOTHERGILL ON HEPATIC DISORDERS.

The functions of the liver and kidneys are closely linked together; and in those derangements where the urine has a thick sediment and the bowels are disordered, the old-fashioned doctor who shook his head and oracularly uttered, "Liver!" was not such a fool as it has recently been the rule to regard him. First cut down the amount of albuminoids eaten or drank, in order to reduce the demand upon the liver; then sweep away the waste from the blood by a pill at bedtime:

Pulv. pip. nig.	grs. ij.
Pil. col. comp.	grs. ij.
and in the morning:	
Soda pot. tart.	5 j.
Soda sulphatis	3 ss.
Tinct. zingiberis	5 ss.
Inf. gentian	5 j.

with an equal quantity of boiling water so as to make the draught as hot as can comfortably be borne. Let this be done twice or thrice a week, till the tongue is clean. When that is done, give the

Soda sulphat.	5 j.
Sod. et pot. tart.	3 ss.
Tinct. nuc. vom.	gtt. vj.
Inf. cascarrille	3 j.

*Ter in die* before meals, and the pill twice a week.

If there be general asthenia, do not proceed to

give iron until the tongue is thoroughly clean, the water clear, and the appetite good; and then commence with two or three drops of the dialyzed iron once a day, after food. In other cases, where there is only slight constipation, with deposits in the urine, especially after meals, give the old-fashioned dinner pill:

Pulv. ipecac.	grs. j.
Pulv. capsici.	grs. ss.
Ext. cinchonæ	grs. ij.
Pil. al. et myrrh.	grs. j.

every day after dinner. It will be found very efficacious. If this dinner pill does not act sufficiently, give the morning laxative twice or thrice a week, so long as the bowels require it. Then as to the union of laxatives with tonics, it is well often to combine these two agents. In convalescence tonics never act genially, if there be not at the same time regular and sufficient action of the bowels; so, add sulphate of magnesia or sulphate of soda to the tonic.—

Mag. sulphat.	grs. xx.
vel sod. sulphat.	5 j.
Quin. sulph.	grs. j.
Ac. phos., dil.	m. xv.
Inf. gentian	3 j.

*Ter in die* before meals, and ten minims of dialyzed iron after dinner, daily, will usually give good results; or,

Mag. sulphat.	3 j.
Tinct. fer. mur.	m. x.
Liq. strychniæ	m. iv.
Morphiæ sulphatis	gr. ss.
Inf. quass.	3 j.

*Ter in die*: forms a less expensive tonic, of much utility.

But in this use of laxatives, with occasional mercurials, avoid the pitfall of letting the patient eat with unlicensed abandon.

Now, in conclusion, let me tell the student to strive to see what are the indications for treatment; what in this case, calls most imperiously for attention. He is taught too exclusively, at present, to look at disease from a deadhouse point of view. To make a diagnosis which would be corroborated in the deadhouse in the great matter. Yes, so it is at a medical school: but in practice for yourself, remember that a living, grateful patient, who has got well under your care, is worth far, far more to you than any amount of accurate diagnosis—which, so far as other persons and their opinions are concerned, is as voiceless to further your interests as the tombstones in the churchyard which mark your failures.—*Indian Med. Jour.*

The British Gynecological Society numbered four hundred before the close of its first year.

## HAMAMELIS IN VARICOSE VEINS.

BY B. F. NICHOLLS, M. D.

In April, 1883, I read in the *Philadelphia Medical Times*, No. 402, an article by Dr. J. H. Musser on "The Treatment of Varicose Veins with Hamamelis." A few days after I read this article, Mrs. W., a married woman, age 35, called at my office on account of swelling and varicose veins of the left leg. On examination, I found the left leg considerably swollen, with here and there large dark spots, which on pressure were quite soft and somewhat tender. These spots were as large as eggs, and situated on the inner aspect of the calf. The right leg was all right. Mrs. W. was three and a half months pregnant with her fourth child. She had always experienced trouble with the veins of her left leg while pregnant, beginning about the third month of pregnancy, and continuing till delivery. In her former pregnancies her leg had been treated by bandaging, which afforded some relief, but her distress was so great that at times she was compelled to seek relief by lying down. I concluded to try the hamamelis and ordered her to take one teaspoonful ext. hamamelis four times a day in a wineglassful of water. She began to improve at once, and continued to take the drug till delivered. Her leg gave her no trouble, the swelling and varicose veins disappearing altogether. Mrs. W. is again pregnant, and the varicose veins appeared again at the usual time. She is now taking hamamelis with success.

The second case is a young colored man, age 30; has had varicose veins for two years. He got some relief from bandaging, but relief was only temporary. Last November he came to my office with a ruptured vein, considerable oozing of blood. Put on a compress and ordered hamamelis, teaspoonful every three hours. Saw him next day, took off compress, no bleeding. Continued hamamelis. Did not see him again for two months, when he reported at my office well. Have seen him several times since, and he has no return of his varicose veins.

The third case was a woman, age 50 years; was a washerwoman; had had varicose veins for a long time; did not remember when they first came; was treated by adhesive strips and bandage, but always returned after the bandages were left off for a short time. I gave her hamamelis two teaspoonfuls three times a day in water. She got entirely well in two months, and has remained so ever since.

The fourth case, a woman, age 47 years, sent for me May 10, 1883. I found her sitting in a chair, bent forward till her face was between her knees, her hands clasped firmly together, her legs stuck out in front, covered with wet cloths. I do

not think I ever saw in my life such a picture of utter hopelessness as this patient. When I approached her, she looked up, and in the most piteous voice exclaimed, "For God's sake, can you do anything for me?" On examining her legs, I found the cause of all her troubles: both legs were a mass of ulcers from the knees to the ankles. From the ulcers was oozing a clear fluid, which soon turned the cloths black. Situated a little behind the knee were several bunches of varicose veins. I thought I had found the original trouble. On inquiry, she said at first, some five years ago, her leg was full of large veins and considerably swelled, and the ulcers came afterwards. I put her on extract of hamamelis, a teaspoonful every three hours, and told her to keep cloths wet with hamamelis applied to the leg. She recovered in two months and all she has left to remind her of her former trouble is considerable discoloration on the anterior aspect of her legs. She walks all about the city, experiencing no trouble whatever.

In conclusion, I would say that I consider hamamelis almost a specific in varicose veins from almost any cause. I did not find it disagree in any way with my patients. It is not at all unpleasant to the taste. — *Philadelphia Medical Times*.

## PERMANGANATE OF POTASSIUM IN AMENORRHOEA.

Dr. Billington recently read a paper in which he first showed the importance of the subject by a reference to the sixty-nine cases reported by Ringer and Murrell, and quoted their conclusions regarding the class of cases in which the drug was useful. Since Ringer and Murrell's article appeared, the remedy had been employed by many other physicians, both abroad and in America, and the results had been tolerably uniform. The author's experience had been limited to four cases, but these, taken in connection with those reported by Ringer and other authors, possessed some significance. In the first case the patient was eighteen years old, chlorotic, and suffering from malarial poisoning. For the nine months that she was under observation she menstruated only once, and then just after the administration of permanganate of potassium. She positively refused, however, to continue the medicine, because of the gastric disturbance which it caused. The second case was that of a girl of seventeen, who had menstruated regularly until a certain exposure to the rain, when the flow became scanty and almost colorless; her health then declined, and she suffered from headache, coldness of the extremities, pallor, etc. Besides other remedies, she was given permanganate of potassium in two-grain capsules, three times a day, but they were discontinued for a time on ac-

count of gastric irritability. Before the next period, the condition of the stomach having been improved, she was able to resume the capsules, when she menstruated normally, and rapidly regained perfect health. The third case was that of a girl about eighteen, who had menstruated regularly, but, without known cause, had ceased to menstruate, and became chlorotic and feeble. Other remedies having failed to restore the menses, permanganate of potassium succeeded. On one or two occasions, however, while the remedy was being continued, a period passed without any flow, probably because such large doses were not given as were said to be necessary in some cases. In the fourth case the patient, who was sixteen years old, had begun to menstruate a year before. The flow had appeared only four or five times, and she had palpitation and shortness of breath. She began with two-grain capsules of permanganate of potassium three times a day, and during the night of the first day, when she had taken three capsules, the flow came on. This patient also complained, after taking the medicine, of an unnatural sensation under the upper part of the sternum.

With regard to the manner in which the remedy acted, different views were held. The author agreed with those who did not believe the beneficial effect was due to its improving the blood and anemic state: some patients so benefited were not anemic, but, on the contrary, were plethoric. There were also conflicting views as to whether permanganate of potassium or other forms of manganese acted as general blood restoratives. Ringer denied it; others held an affirmative view. Regarding the question whether binoxide of manganese was equally efficient as an emmenagogue as permanganate of potassium, the published testimony was not abundant, but Ringer and Murrell thought it was, while Dr. T. Gaillard Thomas considered it equally efficient and much better tolerated by the stomach.

Regarding the method of administration, it had been seen that permanganate of potassium often produced severe gastric disturbance, and some preparations were more likely to produce this result than others. The author preferred to give it in capsules. Its use should be begun a week before the expected menstruation, and, if it acted favorably, might be continued during the interval, or be suspended and resumed at a corresponding period the next month.—*N. Y. Med. Jour.*

remarks, "Very many boys are cut for stone every year, and recover; but I scarcely recollect to have met with a middle-aged adult who had been operated on in childhood." Case—A boy, aged  $4\frac{1}{2}$ , stone in the bladder which had existed for about a year. The usual symptoms were present and well marked, and, upon sounding him, I detected a small and light stone. Dec. 10, under chloroform; dilated his urethra, by passing Nos. 6, 7, 8 and 9 silver catheters in succession. The first three passed readily, but No. 9 was slightly grasped in its passage. Before removing this last catheter, four ounces of antiseptic fluid (corrosive sublimate 1 to 4000) were injected through it into the bladder. This catheter being withdrawn, a small lithotrite, having a diameter about equal to a No. 8 bougie, was introduced along the urethra into the bladder. After a little careful manipulation, the stone was seized, and fixed between the blades. It was then found that, by depressing the handle of the lithotrite, its vesical extremity, together with the stone, could be readily felt through the abdominal wall immediately above the pubes. The lithotrite being held in this position, a small incision, an inch in length, was made in the middle line of the abdominal wall over the pubes, and for a short distance above it. The various tissues were divided, until the wall of the bladder was exposed at the point against which the blades of the lithotrite and the enclosed stone were pressing. A little further depression of the handle of the lithotrite caused the extremity of its blades covered by the stretched wall of the bladder to protrude through the wound in the abdominal wall; and a small incision having been made through the wall of the bladder by cutting upon the extremity of the lithotrite, the blades of the lithotrite, together with the stone, were pushed through the wound. The stone was here extracted from between the blades of the lithotrite; and the open extremity of a No. 7 India-rubber catheter was seized, and drawn into the bladder and along the urethra as the lithotrite was removed, thus leaving a drain for the urine to escape from the bladder. The wound in the abdominal wall was closed by means of two horse-hair stitches, and a drainage-tube introduced into it so as to aid the escape of any urine which might flow from the bladder-wound. Irrigation with corrosive sublimate solution (1 to 2000) was employed, with a dressing of corrosive sublimate wool. The stone removed was about the size of a horse-bean, of uric acid formation. For the first 36 hours the urine was slightly tinged with blood, passed principally by the abdominal wound: but, after this, it flowed through the catheter, which had been secured in the bladder. Forty-eight hours after operation both drainage-tube and catheter were removed, the patient not having had the slightest bad symptom. For 12 hours after the

NEW PROCEDURE FOR REMOVAL OF SMALL CALCULI, Thomas Annandale, F.R.C.S. Ed.—Although lateral lithotomy is a most successful operation in male children, it must, I think, be acknowledged that in the case of small calculi, this operation is a severe one, considering the small size of the irritating body to be removed. Erichsen

removal of the drainage tube and catheter, the urine came by the abdominal wound: but, after this, it passed almost entirely by the urethra, and the patient was running about the ward, perfectly well, on the tenth day after the operation. It may be said that this is simply a suprapubic lithotomy, and so it is, but I maintain that it is a much less serious proceeding than the ordinary suprapubic operation, as the bladder is scarcely disturbed, and the wound made in it is very limited. Its advantages over lateral lithotomy are:—1. That the urethra, prostate, and neck of the bladder are left uninjured; 2. That it is a much more simple proceeding, and does away with the principal risks which have occasionally been encountered in performing the operation on children. It requires a little manipulative dexterity to seize the small stone, but not more than a surgeon should possess. In certain cases the same principle might be carried out, by bringing the stone to the neck of the bladder, opening the prostatic part of the urethra, and thrusting the blades of the lithotrite and contained stone into the perineal wound; but in the case of children there can, I think, be no doubt that the suprapubic method is preferable.—*Brit. Med. Jour.*, Jan. 2.

#### THE MANAGEMENT OF PLACENTA PREVIA.

At the close of an interesting paper on this subject, Dr. Malcom McLean, of New York, offers the following rules in dealing with placenta previa:

First. In any case avoid the application of all chemical styptics, which only clog the vagina with inert coagula, and do not prevent hemorrhage. At the very first, the patient should be put in a state of absolute rest—body and mind—and a mild opiate is often desirable at this stage to quiet the irritation.

Second. Inasmuch as the dangers from *hemorrhage* are greater than all else to both mother and child, at the earliest moment preparations should be made to *induce* premature labor, and labor being once started, the case should be closely watched to its termination by the accoucheur.

Third. In primiparae, the mothers with rigid tissues, the *vagina* should be well distended by either the colpeurynter or tampon, as an adjunct to the cervical dilatation.

Fourth. In the *majority* of cases generally, and in all cases especially where there is reason to believe that rapid delivery may be required, it is more safe to rely upon the *thorough continuous* hydrostatic pressure of a Barnes' dilator than pressure by the fetal parts.

Fifth. Where the implantation is only lateral or partial, and where there is no object in hurrying the labor, bipolar version, drawing down a foot, and leaving one thigh to occlude and dilate the os, may be practised according to the method of Brax-

ton Hicks, except in cases where the head presents well at the os, when

Sixth, the membranes should be ruptured, the waters evacuated, and the head encouraged to engage in the cervico-vaginal canal.

Seventh. In the majority of cases, podalic version is to be preferred to application of the forceps within the os.

Eighth. In some cases, in the absence of sufficient assistance or the necessary instrument, the complete vaginal tampon, in part or wholly of cotton, may be applied and left *in situ* until (within a reasonable time) it is dislodged by uterine contractions and the voluntary efforts of the mother. In case of favorable presentation—occiput or breech—the tampon will not materially obstruct the descent of the child, and in some cases the tampon, placenta, and child will be expelled rapidly and safely without artificial assistance.

Ninth. The dangers of septic infection by means of the tampon or Indian-rubber dilators are so slight, if properly used, as not to be considered as seriously impairing their great value.

Tenth. Whenever it is possible, dilatation and delivery ought to be *deliberately* accomplished, in order to avoid maternal lacerations.

Finally. As cases of placenta previa offer special dangers from post-partum hemorrhages, septicemia, etc., the greatest care must be exercised in every detail of operation and nursing, to avoid conveying septic material to the system of the mother.

*Absolute cleanliness rather than chemical substitutes for that virtue*, should be our constant companion in the practice of the obstetric art.—*American Journal of Obstetrics*, March, 1886.

VIBURNUM PRUNIFOLIUM IN ABORTION. — DR. W. Macfie Campbell, of Liverpool says: Since the publication of Dr. Wilson's paper in the *Liverpool Medico-Chirurgical Journal* of January, 1885, I have had the opportunity of testing the use of viburnum prunifolium, so much vaunted in America, in several cases of threatened miscarriage, and I can entirely endorse the good opinion he has formed of it. Nothing, probably, in midwifery is more disappointing than the ordinary routine-treatment of miscarriage by opium or Indian hemp on the one hand, or ergot on the other. For these drugs as often act in the way contrary to the prescriber's intention as in accordance with it. How often has a dose of Battley's solution, administered to arrest uterine action, and give rest and ease from pains, been followed by immediate and severe expulsive pains, while the attempt to empty the uterus by a dose of ergot has resulted in a perfect calm, and a disappearance of symptoms.

It is a comfort thus to have some hope of success in dealing with such a condition as miscar-

riage; and although I have so far only the notes of six cases, of which five were successful, yet, these five being consecutive, and the effect exactly following the administration of the remedy, I have no hesitation in my own mind in giving the credit to the viburnum. The case of failure was my first.

*Case 1.*—Mrs. B., two months pregnant, had discharge of blood, with uterine action. She was treated in usual manner, with opium and rest for two days, when extract of viburnum, in two grain doses, three times a day, was ordered. There seemed no effect upon the pains, the os continued to dilate, and the uterus was soon empty. Perhaps the dose was too small; at any rate, I had lost two days, which I take to be the reason of the failure.

*Case 2.*—Mrs. H., pregnant for the seventh time, two months and a half, was awakened by a gush of water early one morning, followed by a bloody discharge. On examination, the os was soft and dilatable. She was kept in bed, and given at once three grains of extract of viburnum every four hours. There was no return of bright blood, and the discharge gradually ceased. The relief of the pain after the first dose was in this case very marked.

*Case 3.*—Mrs. B., in her sixth pregnancy, one night during the fifth month was awakened by the "breaking of the waters," the escape being sufficient to saturate her night-dress and bedclothes. This was followed by pains. I saw her in the early forenoon, and gave three grains of the extract three times a day, and there was no further symptoms.

*Case 4.*—Mrs. G., in the fifth month of her second pregnancy, had a bloody discharge, with uterine pains. The same dose was used, with the same good result.

*Case 5.*—Mrs. W., in the second month of her sixth pregnancy, had already two miscarriages. Two grains of extract of viburnum, three times a day, gave relief, as also a month afterwards, when the same threatening symptoms appeared.

*Case 6.*—Mrs. S., first pregnancy, fourth month. This case was particularly interesting from the fact that miscarriage had been imminent in her case at each monthly period. The first and second attacks occurred in America, when she was given viburnum, and her medical man provided her with a large store of the liquid extract, which he told her was unknown in England. She had an attack at sea, and in due time in Liverpool, and was pleased to discover that the drug could be taken in pill, and was equally efficacious, as the liquid extract is very nauseous. While I was from home she had another attack, in which she was attended by Dr. Westby, who considers she was only saved from miscarriage by the viburnum. During this attack, she took her pills five and six times a day; in fact, her faith was such, that she would have

taken too many. Bromide of potassium was also given to allay nervous excitement.

Two other cases turned up during my absence, both of which completed their miscarriage; and I cannot help feeling that, if they had been treated with viburnum, the result would have been different. One sent for Dr. Westby on the third day; the other was treated by another doctor with opium and morphia hypodermically.

It does not do to build too much on the result of these few cases; but I have been so constantly foiled in my endeavors heretofore to prevent miscarriage, that I hope to have found in viburnum the sure arrestor of uterine action, which we certainly at present do not possess.

As recommended by Dr. Wilson, I prescribe the solid extract prepared from the liquid extract—*British Medical Journal, February 27, 1886.*

**DIAGNOSTIC VALUE OF THE WHITE STREAK IN SCARLATINA.**—This phenomenon, which can be produced by rubbing a soft body upon the skin which is affected with the scarlatinal eruption, is considered by the author an important diagnostic sign of scarlatina which has hitherto been overlooked. When in the normal condition one draws a line upon the skin with a smooth surface, as the rounded extremity of a pencil, and uses moderate pressure, there may be observed at the points touched a white line which lasts for some time. This paleness is due to the moderate excitation of the vasomotor nerves and the contraction of the small vessels which follows it. If the pressure has been very strong, in place of a white line a red line bordered by two white ones is produced. The excitation in this case has paralyzed, temporarily, the small vessels in place of contracting them while in the area which is contiguous where the pressure has been less strong the excitation has led only to constriction of the vessels. In certain diseases the effects which are obtained by this procedure vary greatly. Trousseau, for example, has shown that in patients suffering from meningitis a red line is produced by pressure with the greatest ease, and this has been called the meningitic line. It may also be produced in all the diseases which lead to perturbation of function in the nervous system. Thus, it may be produced in many cases of typhoid fever, in erysipelas, variola, rubeola, and the diphtheritic eruptions. But it is not the same in appearance in scarlatina during the entire period of the eruption. In place of getting the red meningitic line, a pale, rather persistent line is produced, which extends plainly to the bottom of the eruption. This fact was long ago noticed by Bouchut, and was considered a valuable sign as a means of diagnosis, both in children and adults. It is not equally prominent and distinct at all periods of the eruption, Velpeau having observed that it is not produced when the

efflorescence of scarlatina is at its highest degree of development. In the diphtheritic eruption, which resembles that of scarlatina accompanied with angina, the excitation of the skin produces a red line and not the white one of scarlatina. This sign is especially valuable in those cases of measles in which the eruption closely resembles that of scarlatina. The same is true in variola, in which other differential signs are often absent. It must be borne in mind that the important feature in making this test is that the white line appears upon the surface which is covered by the eruption. —*Archives of Pediatrics.*

# MEDICAL NOTES. For Sore Nipples.

R. Ziuci sulphatis . . . . . gr. xv.  
Acidi lactici . . . . . gr. xij.  
Glycerini . . . . . ʒ ij.  
Amyli . . . . . ʒ iij. M.

Sig.—Apply with a camel's hair brush between nursings, taking care to wash off before putting child to breast. *Medical Monthly.*

## For Whooping-cough.

Rothe (Memorabilien) recommends the following after an experience of fifteen years in its use:

R. Acidi. carbolic. . . . .  
Spts. vini rectif. . . . . aa ʒ viiiss.  
Tr. iodini . . . . . gtt. v.  
Aq. menth. pip. . . . . ʒ iss.  
Tr. belladonnæ . . . . . ʒ xv  
Syr. diacodii . . . . . ʒ ijss. M.

Sig.—A teaspoonful every two hours. *N. Y. Med. Journal.*

## For Gastro-Intestinal Atony.

Nouveaux Remedes gives the following formula for this condition:

R. Tr. nucis vomicæ . . . . . ʒ ij.  
Ext. rhamnus pursh. fluidi . . . ʒ ijss.  
Syrup. . . . .  
Aq. lauro-cerasi . . . . . aa ʒ ij.  
Aq. dest. . . . . ʒ j. M.

Sig.—Three or four teaspoonfuls a day.

## For Cystitis.

R. Tr. elaterii . . . . . ʒ i to ʒ ij.  
Ext. belladonnæ fl. . . . . gtt xv to gtt xxx.  
Aquam q. s. . . . . ad ʒ iv. M.

Sig.—A teaspoonful every two or three hours.

In conjunction with this the patient should drink freely of watermelon seed or slippery-elm bark tea. —Dr. Floyd Clendenen, in *Therap. Gazette.*

## Colic Mixture for Children.

R. Sodii bromidi . . . . . ʒ iv.  
Ol. anisi . . . . . gtt. ij  
Tr. opii camph. . . . . gtt. xxxij.  
Aquam q. s. . . . . ad ʒ ij. M.

Sig.—Shake and give a teaspoonful every hour as required.—*Indiana Pharmacist.*

VICARIOUS GENEROSITY. "A lady of quality," a peeress to wit, sent her butler to a well-known physician, a man who, were we at liberty to mention his name, would be generally recognised as one of the busiest men in London, with the request that the patient might be examined and prescribed for, gratuitously, of course. "My good man," said the physician, "as you are my lady's butler, you are not a suitable person to be treated at the hospital where I see poor patients for nothing; in my own consulting room, my time is too valuable; here is a guinea, go and see my junior colleague, Dr. —; he is not so busy as I am, and will be able to advise you for that fee." Her ladyship, it is interesting and instructive to learn, repaid the guinea next morning. The moral is plain. The profession as a whole does so much charitable work, that many people seem to expect that every member is to give his time and labor at any time and any place, and to any extent which may be most convenient to the patient or his friends. Quite a large enough proportion of the people who go to hospitals have no right to gratuitous advice, and it is asking rather too much of even the most patient and long-suffering to expect that a still more well-to-do class, too fastidious to go to hospitals, should be allowed to invade private consulting-rooms during the morning hours, which are dedicated to remunerative labor. No other profession has such claims made on it. If the butler had been in some legal difficulty, would the family lawyer have been expected to advise him gratis? We trow not.—*Br. Med. Jour.*

AN EASY METHOD OF INHALING MEDICATED VAPORS.—Arthur Hill Hassall, M.D., in the *Lancet*, January 30th, describes a simple form of inhaling apparatus. He takes a glass vessel in the shape of a cylinder two inches in diameter, and nine inches in height. This he fills about half-full of the medicated fluid (he takes, for example, a ten per cent. solution of carbolic acid). The top of the vessel is then closed by a tight-fitting cork, through which pass four glass tubes. The larger tube is the one used for direct inhalation and just penetrates the cork. The three smaller tubes pass to the bottom of the vessel. Now, when air is inhaled from the upper half of the vessel by means of the large tube fresh air passes in through the small tubes and while bubbling up through the fluid becomes saturated with the medicine. The amount of medicine inhaled will be governed by



(a) the dryness of the air entering through the small tubes, (b) the strength and volatility of the medicated solution, and (c) the temperature of the fluid in the vessel. Three small tubes are chosen in preference to one large one for the admission of air, because they will better distribute the air bubbles, and thus bring the air in contact with a greater surface of the fluid. The air can easily be dried before it enters the small tubes by passing it through a chamber of dried chloride of lime.—*Med. and Dent. Jour.*

**REMEDIES FOR SEA-SICKNESS.**—A physician who has had experience at sea says, in the *London Chemist and Druggist*: "After putting out to sea, one of our first troubles is, of course, sea-sickness; and the young surgeon, perchance himself a victim, will frequently be at his wits' end to know how to combat the many forms sea-sickness assumes. The only weapons the Board of Trade supply to meet this foe of landlubbers are chloroform and ether. We have generally found that 10 minims of chloroform in  $\frac{1}{2}$  ounce of brandy will both prevent and cure this cruel tax which Neptune imposes. Ether seems to act better during a paroxysm in  $\frac{1}{2}$  drachm doses given in brandy, or as Hoffman's anodyne. Apomorphia in doses of  $\frac{3}{4}$  of a grain every half-hour cured the writer during a heavy sea in the Bay of Biscay, and any emetic taken in small doses frequently and perseveringly will bring relief. But our sheet-anchors are the bromides, which, unfortunately, are not included in the official medical list. A little of both the bromides of ammonium and potassium is often obtained before sailing. In cases of extreme nervousness and debility with sea-sickness, 20 grains of potassium bromide with 20 minims of chloric ether and a little sal-volatile, forms a good draught every three or four hours until relieved, keeping the patient quiet and recumbent."

**DUMMY PATIENTS.** A writer in an English paper says: "Apropos of doctors, here is a true story: 'The other day I met a poor fellow and his wife who had been suppers at the Adelphi, but who had been compelled to give up, owing to bad health. They were both elegantly dressed; and I expressed my surprise, as I had heard they were in needy circumstances. I congratulated them on the evident gain of wealth which had compensated the loss of health. 'Oh, sir,' said the man, 'these are not our own clothes: they are lent to us by Dr. —.' 'Lent to you by Dr. —.' 'I exclaimed. 'What for?' 'Why, you see, sir, we are superfluous for him, and he finds the dresses.' 'Does he run a theatre, then?' I asked. 'Lor, no, sir!' was the reply. 'Me and my wife, and some of the most respectable-looking of the out-patients at — Hospital, has a shilling to go and sit in his receiving-room for two hours a day. We're what they call

dummy patients.' I 'tumbled' in a moment. The doctor was young, and anxious to have a reputation for a wide practice. Patients calling found his rooms crowded, and gathered from the fact that he had a widespread reputation."

**TREATMENT OF PHTHISIS BY SUBCUTANEOUS ADMINISTRATION OF CARBOLIC ACID.**—Dr. Filleau, of Paris, reports that he has derived excellent results by the employment of carbolic acid hypodermically in the treatment of phthisis pulmonalis.

Being a firm believer in the parasitic origin of phthisis, he searched for an antiseptic or germicide which could be injected into the blood without harm to the patient. Iodoform was tried, and failed. But chemically pure carbolic acid seemed to answer all requirements. It is easily miscible with water, can be injected without pain, and never causes abscess or phlegmosis. Moreover, it has been demonstrated by Paul Bert that carbolic acid is eliminated by the lungs as well as by the kidneys, thus reaching the favorite seat of the bacilli, and acting like an antiseptic lotion. It was further observed that the bacillus tuberculosis was quickly destroyed by very weak solutions of this antiseptic.

The formula for the preparation of Dr. Filleau's solution is:

R	Acid, carbolic, c. p.,	1 pt.
	Glycerini puri,	4 pts.
	Aq. destillat.	94 pts. M.

SIG.—100 minims once a day, or every other day, according to the case.

The carbolic acid must be perfectly pure. That having a rose color should be employed. The treatment should be continued persistently unless symptoms of intoxication appear, in which case the medication should be dropped.

Dr. Filleau has employed this treatment with very satisfactory results for two years. Several of his patients have been exhibited at the hospital Cochin to the profession. He summarizes his theory and treatment as follows:

1. The parasitic origin of tuberculosis being admitted, carbolic acid, c. p., must be considered the best antiseptic to be employed in the treatment of tubercular diseases.

2. Carbolic acid is the only germicide which can be administered subcutaneously for a long time without danger.

3. The safety and toleration of carbolic acid given hypodermically have been thoroughly demonstrated.

4. By means of this treatment, the general condition of the patient is rapidly improved, and the local lesions are favorably modified.

5. The treatment in every case should be persistently carried out.—*Buffalo Med. & Surg. Jour.*

**HYDRASTIS IN THE TREATMENT OF GRANULATED EYE-LIDS.**—Miss W—— called at my office December 3d. Said she had been afflicted with sore eyes—granulated lids—for some time, and that she had been treated by Dr. M——, allopath, for three months and had received no benefit, in fact, became worse. And that her friends had advised her to try the new doctor.

I concluded that Dr. M—— had exhausted the cut-and-dried routine of treatment, and that in order to succeed I would have to resort to something out of the usual line.

Knowing the beneficial influence of hydrastis on the mucous membrane as an astringent, I concluded to give it a trial. I used the specific tincture, full strength: one drop applied morning and evening with an ordinary dropper. On the evening of the second day the inflammation was considerably reduced and a general improvement was noticeable. In fact she stated (to use her own words), "I believe, doctor, they are about well."

I then gave her the necessary instructions to continue the treatment at home. That was the last I saw of my patient (likewise my fee). But meeting a friend of hers on December 10th, I inquired after my patient, and was somewhat surprised to learn that she was entirely well, and that she had gone to work (dressmaking).

The above treatment may not be new to some; however, I do not remember having seen any reports of the use of hydrastis in the above disease. —Dr. F. P. Mitchell, in the *Cal. Med. Journal*.

**WHITE OF EGG IN OBSTINATE DIARRHŒA.**—From the *Ally. Med. Cent.-Zeit.* we learn that Celli has recently called attention to the curative properties of the albumen of hen's eggs in severe diarrhœal affections. In a discussion before a medical society at Rome, he advocated its use, and related two cases of chronic enteritis and diarrhœa which, having resisted all treatment, speedily made complete recoveries under the use of egg-albumen. The same diet is strongly recommended in the diarrhœa accompanying febrile cachexia and in that of phthisis. In two cases of diarrhœa dependent upon tertiary syphilis, it was found of no avail. On post-mortem examination, diffuse amyloid degeneration of the arterioles of the villi was found in these cases. The whites of eight or ten eggs are beaten up and made into an emulsion with a pint of water. This is to be taken in divided quantities during the day. More may be given if desired. The insipid taste can be improved with lemon, anise, or sugar. In case of colic, a few drops of tincture of opium may be added. —*The Epitome*.

**TREATMENT OF TYPHOID FEVER.**—Dr. W. B. Reynolds, gives the following in the *Medical World*:

Just as soon as I *suspect* a patient to have typhoid fever, I immediately order him to bed and put him on a diet consisting of milk, soft-boiled eggs and beef tea, or animal broths. I consider the early putting to bed of the utmost importance, and I particularly insist that the patient must maintain the recumbent position until convalescence is well advanced. Absolute rest of both mind and body, with perfect quiet, is strictly enforced. For the distressing headache, generally present in the beginning of the disease, I usually afford relief with the following: R. Quinine valer. gr. ij.; ext. belladonnæ, gr. ¼; ext. aconiti, gr. 1-6 M.—Put in one capsule. Sig. One every three or four hours.

**MILK-DIET IN CHRONIC NEPHRITIS.** In view of the fact that milk-diet had been emphatically recommended by many observers, Dr. Trubatcheff undertook a series of comparative observations on four patients with chronic nephritis (three with the parenchymatous, one with the interstitial form), each of whom received ordinary hospital diet during one period, and either mixed or pure milk-diet during a subsequent period of equal duration. The results are as follows: 1. An exclusive milk-diet invariably led to a marked increase of the daily and percentage amount of albumen in the urine. 2. The patient's weight fell considerably, without any marked change in his dropsical state. 3. A mixed milk-diet also led, in the majority of cases, to an increase in the daily and percentage amount of albumen excreted. 4. Neither pure nor mixed milk-diet produced any marked increase in the amount of urine. The author is now studying the assimilation of protein by nephritic patients receiving milk-diet, which study will enable him to settle the question of the treatment. —*London Medical Record*.

**THE TONGUE IN DISEASE.**—A white-coated tongue indicates febrile disturbance. A brown moist tongue, disordered digestion or over-loaded primæ viæ. A brown dry tongue depressed vitality, as in typhoid conditions and blood poisoning. A red moist tongue, debility, as from exhausting discharges. A red dry tongue, pyrexia, or any inflammatory fever. A "strawberry" tongue with prominent papillæ, scarlet fever or rotheln. A red glazed tongue, debility, with want of assimilative power of digestion. A tremulous flabby tongue, delirium tremens. Hesitancy in protruding the tongue, concussion of the brain. Protrusion at one side, paralysis of the muscles of that side. A bluish glazed tongue with cracks or loss of epithelium, tertiary syphilis. A white patch on the tongue, psoriasis linguæ. Thickened epithelium of the tongue, ichthyosis, which frequently leads to epithelioma. Chronic ulceration of the tongue.

decayed teeth, tertiary syphilis or epithelioma. — *Med. World.*

**ARTIFICIAL RESPIRATION IN SUNSTROKE.**—A medical man writes to one of our English exchanges that he treated a case of sunstroke, in the end of March, by employing artificial respiration (Silvester's method), when, after the usual treatment was employed, he could not detect the least sign of breathing, though the heart was acting strong and well at first. The patient regained consciousness in about ten minutes and recovered.

The success of the mode of treatment employed in this case throws a light on the pathology of the state of the lungs seen in some cases of death from sunstroke.

In a case of passive congestion of the lungs in enteric fever, he caused the patient to inspire deeply six or eight times every half-hour for several days, and also attended to the posture of the patient; the result was recovery. — *Med. and Surg. Reporter.*

**ACUTE PLEURISY.**—Professor Da Costa often orders —

Tinct. aconiti rad. . . . .	min. xxx.
Potassii acetatis . . . . .	$\frac{5}{3}$ ss.
Liq. potassii citratis . . . . .	$\frac{3}{3}$ ij.
Syrup. tolu. . . . .	$\frac{5}{3}$ j.

M. Sig.—Two teaspoonfuls every three hours.

In chronic pleurisy Prof. Da Costa has obtained excellent results from—

Potassii iodidi. . . . .	$\frac{5}{3}$ ij.
Tinct. digitalis . . . . .	$\frac{5}{3}$ ij.
Tinct. opii camph. . . . .	$\frac{5}{3}$ iss.
Aque . . . . .	$\frac{5}{3}$ ss.

M. Sig.—One teaspoonful four times a day. — *Med. Bul.*

**CALOMEL AS A DIURETIC.**—The action of calomel in causing diuresis in morbid conditions with dropsy is not generally recognized. In health, indeed, it may be said that the drug has no such action. Dr. Jendrassik has found in cases of cardiac dropsy that calomel in appropriate doses causes well-marked diuresis, a "sort of diabetes insipidus," by which the results of want of cardiac compensation, dropsy and oedema, are dissipated. The effect comes on within twenty-four hours, one and a half grains of the drug being given three to five times a day. No diarrhoea is usually produced; but in some cases it had to be prevented by the administration of laudanum. Salivation and stomatitis were obviated by the prescription of a chlorate of potash gargle from the first. The result in all cases in which the treatment was adopted was beneficial, no unfavorable depressing symptoms being noticed. — *Brit. Med. Jour. Feb. 13.*

**RULES FOR PREVENTING THE PROPAGATION OF TUBERCULOSIS.** The Council of Hygiene of the Department of the Seine has just adopted and published the following series of instructions:

"The most active agent in the transmission of tuberculosis exists in the sputa, which should, therefore, never be deposited on the floor or on the linen, where it may be converted into a dangerous power

"The patients in question must be instructed to expectorate in vessels containing sawdust; the contents of these vessels must be daily thrown into the fire, and the vessels themselves washed in boiling water at least once daily.

"The furnished apartment of a phthisical patient, especially in case of his decease, must be completely disinfected, together with all bedding, and the clothing of such a patient must not be used until it has been subjected to the action of steam." — *Gaz. Méd. de Paris.*

**TREATMENT OF VASCULAR TUMORS.**—Dr. Fiorani has successfully employed the following mixture in six cases of telangiectatic tumors:

Mercuric bichloride . . . . .	3 parts.
Collodion . . . . .	20 parts.

The liquid is applied with a fine brush to the seat of the tumor, four coats being thus superimposed, and care being taken each is thoroughly dry before the next is applied. A crust is shed in four days and the fluid again applied as before, until the tumor has disappeared. This treatment is described as absolutely painless; and the resultant pink discoloration soon disappears. It is applicable only to flat swellings—*i. e.*, those not much more than a line in thickness. — *Gaz. Hebdom. de Montpellier.*

**BROWN-SEQUARD'S MIXTURE FOR EPILEPSY:**

Iodide of potassium, . . . . .	8 parts.
Bromide of potassium, . . . . .	8 parts.
Bromide of ammonium, . . . . .	4 parts.
Bicarbonate of potassium, . . . . .	5 parts.
Infusion of calumba, . . . . .	360 parts.

Dissolve. A teaspoonful before each of the three principal meals, and three dessertspoonfuls on going to bed. The solution should be given diluted in cases of idiopathic epilepsy.

If the pulse of the patient be feeble, the potassium bicarbonate is replaced by ammonium carbonate, while for the 360 parts of infusion of calumba there are substituted 90 parts tincture of calumba and 270 parts of distilled water. — *L'Union Médicale.*

**CHRONIC ENLARGEMENT OF TONSILS.**—In answer to Dr. Gaff's inquiry in regard to hypodermic injections in the above named condition: Dr. Beresford, in the October number of the *Medical Ad-*

vocate, says: "By the use of a strong solution of tannic acid injected two or three times a week, with the daily use of a gargle of the same, the knife need never be resorted to." I have used the above treatment in the case of a young man, æt. about twenty years, with good success. I make an application of muriate cocaine before inserting the needle, and used the injection every three days. — *Cal. Med. Journal.*

**CARBOLIC ENEMATA IN TYPHUS FEVER.** The results which had been obtained from carbolic enemata in typhoid fever by Desplats, Van Oye, and Romanet, induced Dr. A. P. Solonoff, of the Irkutsk Military Hospital, to try the same plan in six cases of typhus fever (*Proceedings of the Eastern Siberian [Irkutsk] Medical Society, 1885, p. 92*). The treatment commenced from the third, fourth, sixth, seventh, and eighth days of the disease, and consisted in the administration of two enemata, at intervals of two hours daily; each enema being made of two ounces of a 1 per cent. solution of carbolic acid (that is, containing 10 grains of the acid). The results, as drawn from observation of the action of fifty enemata, are these: 1. Carbolic enemata, made of two ounces of a 1 per cent. solution, do not produce any tenesmus, the whole amount being absorbed by the rectal mucous membrane. 2. They invariably bring about a depression of the febrile temperature, amounting from 0.2° up to 1° C. [The author never saw any considerable falls, such as 2° or 3° C., which had been noted by Desplats and Romanet.] 3. The decrease begins in about fifteen minutes after the injection, and lasts two hours, or even longer. 4. The depression caused by an enema may be kept at a given level by administering a second enema two hours later. 5. The antipyretic effects of simple cold water enema (1½ pounds) are equal to, or even surpass, those of the carbolic injections; but the former are sometimes soon ejected by the rectum, and then, naturally, do not produce the action desired; moreover, in some cases they cause, after a temporary fall, a considerable elevation of the temperature. 6. In view of their technical simplicity and cheapness, carbolic enemata deserve a preference to the quinine treatment; the latter drug, in small doses, is entirely inactive in typhus fever (as well as in typhoid). 7. Carbolic enemata are, as to their antipyretic action, by far inferior to cold and prolonged lukewarm baths, and must be resorted to only when the baths are either impracticable or contra-indicated by the patient's state. 8. No toxic action was observed, though the daily dose of carbolic acid was as large as twenty or even thirty grains.

**VICARIOUS MENSTRUATION.**—Dr. White relates the particulars of this case in a foreign exchange, occurring in a young girl aged 14, the child of

parents in a good position. Commencing as an abrasion of the lower lip which bled freely, when first seen by Dr. White there were five deep fissures, from which blood flowed freely, and which was only arrested by direct pressure. After a time, the bleeding, instead of being more or less constant, became periodic, these discharges corresponding also to the menstrual periods, at which time the discharge was scanty. Examination of the blood showed, Dr. White thought, that it was different from ordinary blood, and strongly resembled menstrual fluid. The girl was seen at different times by a large number of eminent London practitioners, and as many different opinions as to the nature of the affection were expressed; only one suggested that it might have been self-inflicted, and that the patient kept up the irritation. Inherited taint was suspected, but denied. On the supposition of hysteria, a careful watch was made by the friends, but no evidence of self-infliction was detected. Matters reached a grave issue, life appeared in question, and Dr. White removed her to his own house, and, under chloroform, applied nitric acid, to the deep fissures. The result was excellent. A good deal of deformity resulted, which was treated by closing the fissures as a hare-lip would be treated. Dr. White had noticed, since the recovery, that the onset of the menstrual periods was always accompanied by deep flushing of the lip, as if bleeding was threatening to break out again. The girl was of a hysterical nature, and, after the cauterization, suffered from hysterical paraplegia. After the wounds healed, menstruation became properly established. Dr. White discussed the views held by different writers on the subject of vicarious menstruation; and whilst dwelling upon the aspects of the case, pointed it out as belonging to such a class of cases though he felt by no means positive on the subject. — *Compend. of Med. Science.*

**PESSARIES.**—Dr. Henry K. Leake thus concludes an article on the subject in the *Texas Courier-Record of Medicine* for January:

*First,* That, whilst there exists great difference of views as to the expediency of using pessaries, the practical gynecologist also is influenced in his opinions by his own individual experience, and will not servilely bow to the authority of those who, perhaps, reject such aids on insufficient grounds.

*Second,* That the classical pressure symptoms, including weight in the pelvis, sacralgia, bladder and rectal irritation, difficulty and pain on locomotion, dragging pain in hips and lower abdomen, etc., combined or uncombined with systemic effects, are relieved by a skilful adjustment of pessaries, and must be continued to be held as an indication for their employment.

*Third,* That in all cases of anæmia, neurasthenia, hysteria, presenting themselves, the cause

may be located in some displacement of the pelvic organs, and this point should be determined by immediate examination.

*Fourth*, That due regard must be had to the natural mobility and normal position of the uterus in the placing of pessaries.

*Fifth*, That the Hodge pessary and its modifications are the most scientific and rational instruments we possess, and should be used, if possible, to the exclusion of all others.

*Sixth*, That, contrary to the general view, retroflexion can be redressed and maintained in position by a skilful adjustment of the traction-lever pessary.

*Seventh*, That pessaries should be fitted and placed with the patient in Sims' position, this being the most favorable for such procedure.

*Eighth*, That while the evidence thus far has been discouraging as to the curability of uterine displacements by means of pessaries, we must at least acknowledge their powerful aid as palliatives, and we are justified in believing that the future statistics will demonstrate their greater efficacy in tables showing permanent results. — *Compendium of Med. Science*.

**TREATMENT OF CARBUNCLE WITHOUT INCISION.** — In the course of a paper on this subject before the American Medical Association, by Dr. L. Duncan Bulkley (*Med. News*, 9th May, 1885), the author related the case of a gentleman, aged fifty-six, large and florid, who suffered for several years with eczema of the left foot. He was also diabetic. Following upon this eruption was a large carbuncle. He applied to this tumor, thickly spread on the woolly side of lint, the following ointment:—

R	Ergotæ fl. ext.	5ij	
	Zinci oxidi	3ss	
	Unguenti aq. rosæ	5ij.	M.

Covering this was cotton-wadding, to prevent blows or injury. He was given sulphide of calcium, 1 gr. every two hours, and occasionally the following:—

R	Magnesiæ sulphat.	3iv	
	Ferri sulphat.	5j	
	Acidi sulph.	5iiiij	
	Syr. zingiberis	5j	
	Aquam	ad 5iiij.	M.

S. Teaspoonful in water through a tube three times daily.

At bedtime Dover's powder was administered to give rest when required. The result of the treatment was cessation of pain, rapid resolution, and a cure, except some induration, in eighteen days. The man continued at his work. The paper was summed up as follows:—(1) Avoid any irritation, as pressure, blows, &c. (2) Avoid warmth and moisture, as in poultices. (3) Avoid incisions. (4) Do not use stimulants. (5) Protect the in-

flamed parts with the ointment given above. The solid extract of ergot may be used if desired. Spread the ointment at least one-third inch thick. (6) Use sulphide of calcium every two hours for its effect upon suppuration. (7) Employ good nutritious food, and fresh air. (8) A sedative, if desired, and occasionally the laxative and refrigerant tonic as above. The advantages are:—(1) Short time required for recovery. (2) Cessation of pain. (3) No scar. (4) No operation. (5) No detention from business. — *Glasgow Medical Journal*.

**THE TREATMENT OF PLEURISY IN THE BELLEVUE HOSPITAL.**—Dr. S. Mitchell, of New York, in a recent article states that about 150 cases of pleurisy are treated annually. It is rare to meet with true cases of acute pleurisy, except when they occur in patients while in the hospital. When a case, however, is seen within the first few hours, opium is given, usually as Dover's powder or as Majendie's solution, and hypodermically, which, besides relieving the pain and nervous manifestations, to some extent checks the determination of blood to the pleura. The bowels are opened by salines, and mustard or turpentine applied to the chest. The pain caused by the movements of the chest is greatly relieved by strips of adhesive plaster. Tincture of aconite is given in half-minim doses every fifteen minutes for two hours, and afterwards every two hours until the pulse shows signs of becoming feeble. Quinine in doses of ten grains every six hours is given during the first twenty-four hours. When the state of effusion occurs, the patient is made to take freely of a bitartrate of potassium solution as a diuretic, the saline cathartics are continued, and iodine is applied locally. Another form of local application, which is a favorite with some, is the punctuated cauterisation with Paquelin's cautery every other day. Tonics are given and continued into the third stage, the following formula being that usually prescribed: Strychninæ Sulph. gr. i, Liq. Pot. Arsenit. 5 ij, Citrat. Ferri et Quininæ 3 iv, Glycerini Aq. Cinnam. part. equal. ad 3 viii; a drachm after meals. With this is often given an ounce of whisky three times a day. A drachm of the following mixture is also given occasionally to allay the cough: Morph. Sulph. Pot. Cyanid. aa. gr. ij, Syr. Tolut. Syr. Prun. Virg. part. equal. ad 3 ij. Blisters are seldom employed. When the effusion is great enough to cause much dyspnoea, paracentesis is performed at the mid-axillary line in the sixth interspace, the fluid being withdrawn slowly and arrested at the moment when the patient begins to cough or feel other unpleasant symptoms. In the chronic form of the disease the patient is put on diuretics, tonics, and mild cathartics, and counter-irritation is kept up by Corson's paint, made of Ol. Tiglii 5 ij. Aetheris 5 iv, Tr. Iodi. Co. ad 3 ij. This painted on every morning

produces a crop of pin-head blisters with very little annoyance. When absorption does not occur, this has seemed in many cases to become stimulated by aspiration, a few drachms of liquid being removed by means of a hypodermic syringe, this often rendering paracentesis unnecessary. — *Therap. Gaz.*

**NEW SIGN OF TRICUSPID REGURGITATION.**—Dr. Pasteur, of the Middlesex Hospital, writes: In several cases in which there was reason to suspect functional incompetence of the tricuspid valve, which have recently come under my observation, a physical sign has been present to which I believe attention has not been drawn, and of which I have been unable to find any mention either in the standard text-books or in the best known monographs on the subject of cardiac disease. This sign consists in a distension—with or without pulsation—of the superficial veins of the neck, occurring when firm pressure is exerted over the liver in the direction of the spinal column, and independent of the movements of respiration. A little consideration of the anatomical relations of the parts concerned will suggest the facility with which an impediment may be created to the flow of blood, in either direction, through the vena cava inferior by such a manœuvre, especially when the liver is obviously enlarged. It seems to me that the state thus produced is virtually that which obtains as a chronic condition in long-standing and severe cases of tricuspid incompetence as far as regards the tension in the systemic venous system in the immediate vicinity of the heart. Assuming the existence of tricuspid regurgitation and of a source of compression of the vena cava inferior, it is obvious that with each systole an excessive reflux of blood must take place into the vena cava superior and its tributary veins. It may be noted that the question of pulsation, as compared with distension or undulation, is merely one of degree of morbid venous tension. Although the number of cases in which I have observed this phenomenon is certainly limited, I have never failed to elicit it when there was indubitable evidence of tricuspid incompetence; on the other hand, I have hitherto invariably failed to obtain it in other forms of cardiac valvular disease, and in various cases of hepatic enlargement from causes other than passive congestion. I cannot but think that this sign may furnish an important aid to diagnosis in cases where the usual signs of tricuspid regurgitation are ill-developed or in abeyance, and that it may prove a valuable factor in the difficult general problem of prognosis in cases of cardiac disease. My chief object in making this short communication is to draw attention to a point which I believe to be of some importance, with a view to stimulate observation, and it may be to elicit further facts. — *Lancet.*

**ELEVATION OF THE ARMS AS A SYMPTOM OF PERITONITIS.**—Dr. Lediard calls to mind that there are various circumstances rendering the attitudes assumed by the sick of great diagnostic value. It may be that extreme restlessness, delirium, or fear, may prevent accurate noting of the pulse, temperature, respiration, or even physical examination of diseased organs. Again, deaf-mutism, malingering, a foreign language, etc., may further entail difficulties in diagnosis which might be in some measure overcome by the observance of a well established position pathognomonic of a disease. He then alludes to one disease and one posture, which seem to be rarely dissociated, at least in the adult. Many years have passed since he was first struck with a posture which he has generally found to be a truthful indication. On November 19th, 1871, a waiter, aged twenty-two, was brought into the Edinburgh Infirmary, under the care of the late Professor Spence, whose house-surgeon he then was. The patient had been stabbed in the abdomen, and a foot of small intestine was protruding. On the day following admission the patient was noticed to keep his hands above his head with the elbows out—i.e., in a position often assumed when one is lying on the grass in summer enjoying the sounds of nature. Subsequently, but within twenty-four hours, he was observed to raise the left thigh: finally, the hands were constantly behind the head and the knees completely drawn up. Death occurred on the fourth day from general peritonitis. In peritonitis following the operations for hernia, gastrotomy, ovariectomy, ruptures of the bowels following violence without external mark, and in puerperal peritonitis, the author has constantly observed the position taken by the patient to be similar to that described. The raising of the arms is, in his belief, coincident with the commencement of peritonitis, and when the inflammation is at its height the hands will be clasped behind the occiput. The explanation is simple enough: the object being to lift all pressure from the distended bowels, the respiration becomes thoracic and the diaphragm fixed: by raising the arms the pectoral muscles elevate the ribs, and more room is thereby allowed for lung expansion: the raising of the arms moves the scapula upward and forward, and the serratus magnus being drawn upon still further tends to relieve the thorax from pressure, while the dorsal position of the trunk with an extended spine favors respiratory movement. — *Lancet.*

**THERAPEUTIC NOTES.**—Dr. Yeo, of King's College Hospital, in his opening lecture in the course of clinical therapeutics, is reported by *The Lancet* as having made the following practical observations:

1. That in order to derive the full beneficial effect from iodide of potassium in cases of aneur-

ism, the drug must be given in twenty or thirty grain doses three times a day.

2. That arsenic, besides acting well in chronic skin affections, is often of service in cases of angina pectoris, asthma, neuralgias (especially the visceral forms), and in some kinds of anemia.

3. That aconite is much more certain in its action when given to reduce the temperature and other symptoms of local inflammations in children than it is in the case of adults.

4. That the topical application of opium is a much neglected but useful remedy for the relief of local inflammations, especially when these are traumatic.

**REMOVAL OF FRECKLES.**—Dr. Halkins, in the *Journal of Cutaneous and Venereal Diseases*, says that freckles may be removed by carbolic acid as follows: Put the skin on the stretch with two fingers of the left hand and apply a drop of pure carbolic acid exactly over the patch. The skin will burn and turn white, but the burning sensation will disappear in a few minutes. The thin crust which forms after the cauterization must not be disturbed and it will be cast off in eight or ten days, leaving a rosy discoloration which is soon displaced by the normal skin. *Med and Dent. Jour.*

**TREATMENT OF ACUTE RHEUMATISM.** Dr. R. H. Fox states in the *Brit. Med. Journal* that in a severe case of rheumatism in which salicylate of sodium, potassium, quinine, colchicum and liniments had all failed to relieve the fever and pain, the relief was immediate after sponging with cold water and quickly drying the skin afterward. Although this is no new treatment, it is one which requires some courage to practice, and yet may be well adapted to certain severe cases in which the salicylic remedies are ineffectual. — *Therapeutic Gazette.*

**MIXTURE FOR THE ANOREXIA OF PREGNANCY.** Forwood recommends the use of the following mixture in cases of loss of appetite in pregnant women:

Pulverized calumba root,	
Pulverized sugar root . . .	aa 15 parts.
Senna leaves . . . . .	4 parts.
Boiling water . . . . .	475 parts.

Infuse. A wineglassful before each meal. — *L'Union Médicale*, Feb. 27, 1886.

**TUBERCULAR INFECTION THROUGH SEXUAL INTERCOURSE.**—In the *Medical Times* Fernet points out the probability of tubercle being thus conveyed. Indolent blenorrhagic discharges in men, and certain forms of leucorrhœa in women, should be

looked on with suspicion, and searched for the bacillus tuberculosis. Sexual intercourse with the subjects of genital tuberculosis should be avoided. In individuals affected with genital tuberculosis there is a risk of general auto infection, and the tuberculous matter should be removed. — *Med. and Surg. Rep.*

**DILATATION OF THE HEART.**—Professor Da Costa recommends:

R	Pulv. digitalis . . . . .	gr. iv.
	Strychniae sulphatis . . .	gr. $\frac{1}{4}$ .
	Ext. belladonnæ . . . . .	gr. ij.
	Ferri sulphatis . . . . .	gr. xvj.
M.	Ft. pilulæ No. xvi.	

Sig.—One pill after meals. — *Med. Bul.*

**IODOFORM IN UTERINE CATARRH.**—Kugelman, having noticed that iodoform very promptly cures coryza and laryngitis, concluded that it would be beneficial in cases of uterine catarrh. He introduced the powder into the uterus by means of a very fine catheter. The applications were renewed twice a week, and with excellent results. The catarrhal hypersecretion diminished or ceased immediately in every case. — *Gazet. Med. de Paris.*

**FOR DYSPEPSIA.**—Five to ten minims of glycerine of carbolic acid in a little water, after meals, is an admirable remedy for dyspepsia, and for the impaired digestion of tea-drinkers and tobacco-chewers. Especially in this useful (in smaller doses) in the dyspepsia of children, associated with the presence of worms in the alimentary canal. Glycerine is in itself an anthelmintic of much power.

Prof. Da Costa considers the iodide of potassium the only remedy deserving of confidence in the treatment of *internal aneurism*. He gives gr. xv. *ter die*, increased to the point of tolerance. In addition, he keeps the action of the heart subdued by aconite: for pain, ice over the tumor, and rub with an ointment of aconitia gr. j to vaseline  $\frac{3}{4}$  j. A quiet life, rest in bed and a dry diet, are enjoined upon the patient. *Col. and Clin. Record.*

Dr. W. H. Richardson of New York says: I have used the Smith & Shaw Closed Cell Pocket Battery daily in my practice and am highly pleased with it. I find it so portable that I can carry it about in my coat pocket when making my professional visits, without any inconvenience. My patients say that the current from it is more agreeable than that of my large battery of a different make, it being more smooth and uniform. In my hands it has given entire satisfaction and met all the requirements



# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MAILLER, 23 Rue Richer, Paris.

TORONTO, MAY, 1886.

*The LANCET has the largest circulation of any Medical Journal in Canada.*

## TOO MANY DRUGS.

The innumerable host and indescribable variety of drugs have become an intolerable burthen to the student, the pharmacist and the physician, and a bane to the afflicted patient. What, with the various tinctures, extracts, alkaloids, etc., of every thing that is in heaven above, or in all the earth beneath, or in the waters under the earth, and their infinite combinations, we are overwhelmed. But a very superficial knowledge can possibly be acquired of our *Materia Medica*, by the most industrious student or physician. With the exception of a comparatively few standard remedies, our knowledge of the chemical, physiological, and therapeutical actions, is too vague to admit of intelligent prescription. Yet, fashion almost compels us to prescribe the new remedies, not because our own experience, or that of the profession, has established their efficacy: but because we desire to be up to the so-called advance of science. Many, we fear, prescribe remedies of which they have but limited knowledge, theoretical or practical; not so much in the interests of the patient, perhaps, as in their ambition to be fashionable; and often take credit for their supposed superiority, over the Rip Van Winkles, who still cautiously prescribe those remedies, whose virtues have been established by the test of time. How many of those vaunted new remedies have succumbed to that almost infallible test within the last twenty years, and how many of the present and future will succumb during the

next twenty, it is impossible to enumerate or predict. Yet, fashion will continue to predominate, often, we fear, at the expense of the patient's health, and even life.

It will be admitted that the variety and number of remedies prescribed are usually in inverse ratio to our experience. The young physician, with but a limited theoretical knowledge of *materia medica*, is disposed to vary his prescriptions daily, because of the multitude of remedies placed before him; and to reproach himself for his supposed stupidity and want of success. This frequently results in loss of confidence in all remedies. Whereas, the older physician has, after many failures and grievous disappointments, eliminated all but a comparatively few established remedies, on which dearly bought experience has taught him to rely with confidence.

It might be said that this would hinder if not entirely prevent advance in *materia medica*. But the great majority of our profession have neither time or opportunity for experiments, on a scale sufficiently extensive, to accomplish any good purpose. Therefore, it is in the interest, not only of the doctor and his patients, but of science, to allow new remedies time to become established by the experiments of the minority, whose experience, training and opportunities, enable them to make those experiments in a scientific manner, and on a scale sufficiently large, to command confidence in those preparations which they endorse.

On the other hand, many antiquated remedies and compounds are retained in the pharmacopœia, which might be eliminated without injury to its usefulness. This would, in some degree, relieve the student from almost useless study, and the pharmacist from keeping a stock of articles which are so seldom prescribed, that they deteriorate in value, and become inert through age. Many of the compounds therein described have served their day and generation, and are superannuated by the rapid advance in science in every direction, but more especially by the science of chemistry. The alkaloids, or active principles of most of the vegetable remedies can now be obtained, in which uncertainty of therapeutical action is reduced to a minimum. Hence, many of the preparations and combinations of former days, with their multiple variations in strength and effect are superseded. The shot gun of our fathers should be replaced by the

rifle, with much greater certainty, if our aim be true, of placing the enemy *hors de combat*. But, in order to make true our aim, it is indispensable that we possess the most accurate and intimate knowledge of the remedies used. The infinite number of these remedies, both officinal and otherwise, renders this impracticable. Consequently, the practice obtains of combining an array of remedies in one prescription, with very uncertain results, often we fear with injury to the patient.

Although we are not so culpable in this respect as our ancestors; and, although a physician's knowledge and ability is not now gauged by the number and variety of articles he can combine, as in the days of "Mathiolus' Antidote," containing one hundred and twenty-four ingredients, or "Warburg's tincture," said originally to have contained over sixty; yet, there is room for advance in the simplification of prescriptions of the present day. Polypharmacy and science are necessarily antagonistic, consequently the former should be avoided, if we are to progress in the right direction. Otherwise, it will be necessary to still further divide the healing art, and have specialists in materia medica. However useful this might be to our ever-multiplying profession, it is obvious some objections might be raised by the patient, to furnishing the requisite honorarium to each physician, one to diagnose, and another to prescribe for every ill to which the flesh is heir.

Therefore, we hold that the general physician's armamentarium should be limited to established remedies in their best form; and of these, only such as can be prescribed with confidence, based on careful study of the experience of others as well as his own; and an intimate knowledge of their chemical, physiological and therapeutical properties.

TRINITY MEDICAL SCHOOL.—*Fellowship Degree*: J. McLurg, *Gold Medal*; J. H. Hamilton, *1st Silver Medal*; J. G. Dickison, *2nd Silver Medal*; C. Lapp, W. W. Hay, F. H. Brennan, W. I'Anson.

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*Prizemen*.—A. B. Gillis and J. W. Begg, *Demonstrators of Anatomy*; W. H. Dawson and A. J. Errett, *Hospital Surgeons*.

WESTERN UNIVERSITY, LONDON.—M.D.—H. A. McCallum, *Gold Medal*; J. W. Fraser, R. Gibson, W. Logie, W. J. Weekes, *Honors*; G. H. Wilson, H. K. Hyndman.

*Primary*.—J. D. Balfour, C. D. McDonald.

*Honors*.—O. Groves, J. Haggart, L. Hyttenrauch, J. A. McDonald, D. H. Piper, J. Proudfoot.

*Scholarships*. 1st year, R. H. Homer, M. Wilson; 2nd year, C. D. McDonald; 3rd year, J. D. Balfour.

WOMEN'S MEDICAL COLLEGE, KINGSTON.—M.D. A. E. Dickson, M. Oliver. *Primary*.—A. D. Craine, E. Embury, A. Lawyer, M. Livingston, A. A. Marshall, E. S. Mitchell.

ONTARIO MEDICAL ASSOCIATION. —We beg to draw especial attention to the meeting of the Ontario Association, to be held in Toronto, on the 2nd and 3rd of June. Invitations have been issued to several prominent medical men in New York, Buffalo, Detroit, Montreal, Quebec, etc., and it is expected that the attendance will be larger than upon any former occasion. Intimations of papers to be read, are being received by the Secretary, Dr. White, who regrets that he is unable to publish a full list at present, but who will furnish such list in our next number. We would strongly urge the members of the profession, and especially the younger members, to be present, and take part in the proceedings. The Committee has made arrangements with the various railroads, by which return tickets will be issued at one and a third fares; such tickets also being granted to the wife or daughter of a physician, and to one lady patient. It is proposed to hold a series of social entertainments during the stay of the members in the city, several prominent medical men having kindly offered to throw open their houses for such purposes.

BRITISH COLUMBIA MEDICAL ACT. —Through the kindness of Dr. Milne, of British Columbia, we have received a copy of the Medical Act just passed for this distant Province of the Dominion.

It is based upon the Ontario Medical Act, but contains some changes which are not undesirable. In the first place the elections are to be held annually: the number of members is limited to seven, and every voter is entitled to vote for seven persons. The seven who stand highest on the list shall be declared elected. The only clause which affects us is the following (sec. 28): The council shall admit to registration any person holding a diploma of qualification, from any school or college requiring a three years course of study; providing that the applicant is properly identified and passes before the members thereof, or such of them as may be appointed for the purpose, a satisfactory examination, touching his fitness and capacity to practise as a physician and surgeon. The registration fee is ten dollars. Homeopathic physicians may also be registered on complying with the above terms.

**VIBURNUM PRUNIFOLIUM IN ABORTION.**—Dr W. E. Green, writing to the *Brit. Med. Journal*, speaks very highly of the value of Black Haw in threatened abortion. He has kept notes of some twenty cases, and in two-thirds of them the result has been entirely successful, and in the others, failure was due to some imprudence on the patient's part, or to some other cause, quite beyond the control of the medicine. It has been used more frequently in this country than in England, and all observers so far as we know, hold that its action is generally satisfactory. Mr. Green recommends drachm doses in water every hour while the urgent symptoms last, and then three times a day till recovery. It is well to give a few doses at the time when the menstrual period would ordinarily appear, as there is more danger of abortion then than at other times.

**THE CARTWRIGHT LECTURES.**—Dr. Wm. Osler, of the University of Pennsylvania, delivered the fifth course of "Cartwright lectures" before the Alumni Association of the College of Physicians and Surgeons, New York, on the 23rd of March. His subject was "Certain Problems in the Physiology of the Blood," and the course has been highly spoken of. The first lecture dealt with the blood plaque, which is also known as the elementary corpuscle of Zimmerman, the hæmatoblast of Hayein, and the third corpuscle and blood-plate

of Bizzozero. The second lecture treated of the degeneration and regeneration of the corpuscles. The third and last was on "the relation of the corpuscles to the process of coagulation." It is in connection with this process that the functions of the blood plaques present the most interesting problem.

**SALICYLATE OF LITHIUM IN RHEUMATISM.**—It is well known that certain cases of rheumatism prove utterly intractable to cure by salicylate of sodium. Especially is this the case in gonorrhœal, and in certain forms of chronic articular rheumatism. Vulpien lately read a paper before the Paris (*Deutsche Med. Zeit.*) in which he states that he has had encouraging results from the lithmic salt. In certain chronic cases in which the sodium salt had been exhibited for a long time without benefit, relief was obtained by the use of the lithium preparation. The salt is agreeable to the taste, readily soluble in water, and may be given in doses up to 7 grains. He thinks, however, that the daily ingestion ought not to exceed 1 drachm. The after effects are preferable to those of the sodium salt.

**TREATMENT OF IMPORFORATE HYMEN.**—Dr. Baker, in a paper read before the Boston Obstetrical Society, (*Boston Med. & Surg. Jour.*), says he considers free incision of the distended hymen unsafe, when the fallopian tubes, as well as the uterus and vagina are distended by the retained menstrual fluid. The dangers are, first:—Septicæmia, from the tubes; and second, rupture of the tubes from the increased peristalsis of their walls, excited into action by the contracting uterus. If the tubes are involved, he counsels removing them by laparotomy, and then making a free crucial incision in the hymen so as to empty the uterus and vagina. When the retained fluid does not extend to the tubes he either evacuates with a trocar, or makes the usual incision, taking care to keep the coats of the vagina clean, and apart so as to prevent their union by adhesive inflammation.

**SPARTEINE IN HEART AFFECTIONS.**—Sparteine, the new cardiac agent, bids well to replace digitalis advantageously in certain affections of the heart. M. Honde and M. Sée have studied its properties, and have found it to act in three different ways. It increases the strength of the heart and pulse; it makes the heart beat regular, and causes fre-

quency of contraction. Thus, sulphate of sparteine is indicated in cases of weakened heart, through alteration in its tissue, or through obstruction of its valves. It does not seem to have any effect on the excretion of the urine. M. Honde advises the following formula:—Sulphate of Sparteine, 10 grs.; sugar of milk, 30 grs.; simple syrup, q. s. for 50 pills, two to ten a day; or sulphate of sparteine, 6 grs.; syrup of orange, 10 ounces; three tablespoonfuls a day.

**MUSSEL POISONING.**—An unfortunate instance of poisoning by mussels, *mytilus edulis*, took place recently at Wilhelmshaven. The mussels were collected from two ships not copper bottomed, and eaten, the result being that nineteen persons were poisoned, of whom four died. The symptoms and postmortem appearances were those of irritant poisoning. Dr. Schnidman attributed the poisoning to a polmanie, but with this view Professor Virchow did not agree, but he was inclined to the view that it was due to an akaloid. Small animals were killed by extracts made from the mussels, the activity of which was not destroyed by heat or alcohol, but by a drop of a solution of sodium bicarbonate. Dr. Koch has reported that he had discovered several characteristic bacilli, but as he had not succeeded in propagating them no definite judgment could be pronounced upon them.

**THE VALUE OF ANTIMONY IN THE TREATMENT OF PSORIASIS.**—Mr. James Mason, (*Glasgow Medical Jour.*) strongly recommends the administration of tartar emetic in psoriasis, and details the following case:—A boy æt. 15, for the last year and a half had been troubled with a "scaly skin," which gradually grew worse, till he consulted a medical man under whose treatment he remained for eight weeks without deriving any benefit whatever. He was then put on five minim doses of vin. antim, and in one week his face and head were almost entirely free from scales. The dose was then increased to ten minims four times a day during the second week, and at the end of the third week all trace of the disease had vanished, with the exception of a small white patch on his right elbow.

**LIQUID MALT EXTRACT.**—This new preparation recently introduced by Wyeth & Co., of Philadelphia, promises to become a favorite remedy in the

treatment of wasting diseases. It is well adapted for administration to nursing mothers and delicate children, in neurasthenia and certain forms of dyspepsia. The small percentage of alcohol it contains (less than four per cent.) renders it a safe and effectual preparation for delicate children and invalids.

**APPOINTMENTS.**—T. H. Robinson, M. D., of Kleinburg, to be an associate coroner, for the County of York.

R. W. Bruce Smith, M.D., of Seaforth, to be an associate coroner for the County of Huron.

Alex. Sangster, M.D., Stouffville, to be an associate coroner for the Counties of York and Ontario.

Dr. George I. McKenzie, of Pictou, has been appointed coroner for the County of Pictou, N. S.

**GASTRIC ULCER.**—Dr. G. K. Ter-Grégoriantz, of Tiflis (*Proceedings of the Caucasian Medical Society*), recommends the administration of six drops of an iced solution of perchloride opium, at first six, afterwards, four times daily, an hour before meals, together with a diet composed of an iced mixture of equal parts of milk, and boiled water, with well-toasted bread. An ice bag was also applied on the epigastric region.

**THE ACTION OF ALKALIES ON ALOES.**—It is well-known that the addition of bi-carbonate of sodium or potassium to solutions of aloes considerably diminishes their bitterness. From a series of experiments instituted by Dr. Macdonald, it would appear however, that the effect is produced at the expense of the active constituents of the drug. Hence, in prescribing aloes it is desirable to avoid the addition of alkaline bases.—(*Med. Press and Cir., Lond.*)

**NEW ADVERTISEMENT THIS WEEK.**—Some injudicious friends have been endeavouring to injure the standing of Dr. Carleton, of Markham, Ont., among his professional brethren, by inserting letters in the local paper referring to his successful treatment of piles and *running sores*, and the editor of the paper has added insult to injury by classing them as "new advertisements this week."

**THE USE OF TURPENTINE FOR THE REMOVAL OF INSECTS FROM THE EAR.**—Köhler recommends (*Rev. de Thérap.*) that the external meatus be filled

with oil of turpentine, which should be allowed to remain for five minutes. The ear is then washed out with a syringe, and in nearly every case the insect is brought away without further trouble.

**POWDER FOR USE IN PYROSIS.**—Dr. Monia says, (*L'Union Méd.*) that a teaspoonful of the following powder taken in a wineglassful of water gives excellent results in heartburn :

Pulverized phosphate of zinc	10 parts.
Calcine magnesia, . . .	3 "
Pulverized vanilla . . .	1 part.

**MEDICAL COUNCIL ELECTION.**—We understand that Dr. C. A. Jones, of Mount Forest, is also a candidate for election in the Saugeen and Brock Territorial District Division. There will, therefore, be a triangular contest for the honor of representing this important Division in the Ontario Medical Council.

**VALERIAN IN DIABETES INSIPIDUS.**—Demange says in *L'Union Médicale* that diabetes insipidus is best treated by valerian in doses of two to four drachms of the powder per diem. This drug was highly praised by Trousseau, and has been revived since by Bouchard.

**LIQUID GLUE.**—Fill a bottle with small pieces of best glue, and add as much acetic acid as it will then hold. Treat in a hot-water bath till the glue is melted, and you will have an excellent liquid glue that is always ready.

**REMOVAL.**—We have been requested to announce that Dr. T. Gaillard Thomas, of New York, has removed from 294, 5th Avenue to 600 Madison Avenue, between 57th and 58th streets.

**A WRITER** to the *Cincinnati Lancet Clinic*, says that a sponge moistened with ether or turpentine passed over the surface of adhesive plaster will render it more adhesive. No heat is needed and the plaster adheres evenly over its whole extent.

**DR. J. FULTON**, editor of the *CANADA LANCET*, sailed for Europe on the 1st inst., accompanied by his daughter. He will visit the Hospitals of London, Paris, and Vienna, and will not return before the 1st of October.

The death of Mr. Cooper Forster, of Guy's Hos-

pital, London, Eng., author of "Surgical Diseases of Children" is announced in our exchanges.

## Books and Pamphlets.

**A REFERENCE HAND-BOOK OF THE MEDICAL SCIENCES.** Edited by Albert H. Buck. New York : Wm. Wood & Co., 1885. Vols. I & II.

This work is essentially a collection of articles alphabetically arranged, treating of the more important matters on which medical men are likely to desire information. The work will consist of eight volumes of eight hundred pages each, and will be issued as rapidly as circumstances will permit. Among the list of contributors to volume I. and II. we notice the names of Drs. Bulley, Gardner, Ross, Stewart, Williams and others of Montreal, and we learn that the names of other gentlemen in Canada will figure in the succeeding volumes. The work is, indeed, a great encyclopædia of medical literature. The intention is to embrace within its scope all subjects bearing directly and indirectly upon medicine. The following are a few of the subjects treated of in vol. I :—Abdomen, and tumors of ; abortion, acclimation, acne, Adirondacks, adipocere air, artificial respiration, astigmatism, Avon springs, biology, bioplaxson, bittersweet, blindness, blood, boils, brain, cesarian section, cataract, and many others too numerous to mention, covering upwards of 800 large pages. The work is well-printed and handsomely bound, and will form a valuable addition to the physician's library.

**THE PRINCIPLES AND PRACTICE OF MEDICINE.** by Charles Hilton Fagge, M.D., F.R.C.P., Lecturer on Pathology, at Guy's Hospital, etc. Edited by P. H. Pye-Smith, M. D., F.R.C.P., Lecturer on Medicine at Guy's Hospital. Two volumes. Philadelphia : P. Blakiston, Son & Co.

This work on the practice of medicine, which occupied Dr. Hilton Fagge for the last twelve years of his life, is now before the profession. It is an entirely new work, and is based essentially on the experience of this indefatigable worker in the wards and in the dead-house of Guy's Hospital. We think we are fully justified in saying that, it is the most original and most elaborate text-book on medicine which has yet appeared, and well worthy the memory of its distinguished author. The first volume appeared a short time ago, and

the second is now nearly ready. We heartily commend this great work to the notice of the profession in Canada.

**PRACTICAL HUMAN ANATOMY.**—A working-guide for students, and ready reference for Physicians and Surgeons. by F. D. Weisse, M.D., Prof. of Practical and Surgical Anatomy, University of New York: D. Appleton & Co.

The aim of the author of this practical work on anatomy was to produce a working-guide for the student in the dissecting room, and also a ready reference to the physician and surgeon. The plan adopted is an excellent one, and consists in the division of the body into dissections. There are twenty-seven in all — abdominal parietes, viscera in situ, perineum, front of thigh, front of leg, etc. Descriptive paragraphs are given in connection with each, and copious illustrations are introduced. Special attention has been given to those regions and organs which claim frequent surgical and medical care. The mechanical execution of the work is all that can be desired.

**AN ATLAS OF CLINICAL MICROSCOPY.** By Alex. Plyer, M.D., of Schaffhausen. Translated by A. C. Girard, M.D., Assistant Surgeon, U. S. A., from the second German edition. New York: D. Appleton & Co.

The principal feature of the book is the large number of plates it contains, illustrating the microscopic appearances of the fluids of the body; blood, milk, urine, sputum, contents of stomach and bowels, fluid contents of tumors, micro-organisms, etc. As the work is chiefly intended as an atlas, the author has made the text as short as possible, mentioning only what has to be borne in mind by the physician. Considerable attention has been given to the various diseases of the urethra, bladder and kidneys. The work should meet a hearty reception at the hands of the profession.

**A MANUAL OF DISSECTION OF THE HUMAN ANATOMY.** By Luther Holden. Fifth Edition, edited by John Langton, with two hundred illustrations. Philadelphia: P. Blakiston, Son & Co. Toronto: Willing & Co.

This work is already well and favorably known to the profession both at home and abroad. The work has been most carefully revised and additional matter introduced. It is at the same time as concise as it is possible for a work of the kind to be, and the subject matter is put in as clear and

practical a light as is compatible with the faithful handling of its natural difficulties. The muscles, vessels, nerves, etc., are described as they are successively exposed to view in the process of dissection, a plan now generally recognized as the correct method of teaching the subject. The subject of osteology is dealt with in a separate volume.

**CLINICAL NOTES ON UTERINE SURGERY,** with special reference to the Management of the Sterile Condition. By J. Marion Sims, B.A., M.D., late Surgeon to the Women's Hospital, of New York. New York: Wm. Wood & Co.

The author in his preface states that the facts are strung together from the notes of cases recorded in the Women's Hospital. This collection of "Clinical Notes" lays no claim to the character of a systematic work, but is none the less interesting or useful on that account. Many interesting subjects, such as fistule of the bladder, rectum and vagina, lacerated perineum, etc., have been omitted, for the reason that the author contemplated preparing a fully illustrated monograph on these subjects. The author was too well known in his specialty to require any words of commendation. The profession will gladly welcome this "memorial edition" of the work of so distinguished a gynecologist.

**DISEASES OF THE TONGUE.** By H. T. Butlin, F.R.C.S., Assistant Surgeon St. Bartholomew's Hospital, London. Philadelphia: Lea Bros., & Co.

We gladly welcome this unique and interesting work on diseases of the tongue by Mr. Butlin. The clinical notes and drawings have been made from cases occurring in the large Metropolitan Hospital during a period of years in the practice of the author and his colleagues. The engravings and chromo-lithographs are well executed, and the work is on the whole a most valuable one. No surgeon should be without it.

**PRACTICAL SURGERY,** including, Bandaging, Fractures, Dislocations, Ligature of Arteries, Amputations, Excisions, etc. By J. Ewing Mears, M.D., Lecturer on Practical Surgery, Jefferson Medical College. Second edition with 490 illustrations. Philadelphia: P. Blakiston, Son & Co.

The work before us has been very much improved in passing through the second edition; new matter has been added, and evidence of a thorough



revision is everywhere present. The title page indicates the scope of the work, which is of the most practical character. It will be found especially useful as a work of reference in emergencies.

#### DISEASES OF THE BRAIN AND SPINAL CORD. Gowers.

This is the December issue of the enterprising house of Wm. Wood & Co. No better close of a good year's work could have been presented to the readers of the series. Dr. Gowers has treated the subjects of brain and spinal diseases, as might have been expected at his hand, in a masterly way. The portion of the book devoted to the brain consists of eighteen lectures, in which the following subjects are treated of in clear and simple terms,—viz: Medical Anatomy, Symptoms and Diagnosis, each of which has been exhaustively discussed in conformity with the latest experimental and clinical observances.

The part pertaining to the spinal cord covers about one-third of the book. Perhaps the most valuable portion, to the general practitioner, is that relating to the tendon, or as the author prefers to designate the phenomena, muscular reflexes. The instructions here given are highly important, and cannot fail to prove extremely valuable to those who desire a better acquaintance with this means of formulating a reliable diagnosis of lesions of the cord. It is but justice to the author that we should advise the reader to devote more attention to the precious text, than to the illustrative plates; the former is so excellent that it is a pity it has been rather obscured than brightened by futile artistic decoration.

**THE SURGICAL DISEASES OF CHILDREN.** By Edmund Owen, M.B., F.R.C.S., Member of the Board of Examiners of the Royal College of Surgeons, England. Surgeon to the Hospital for Sick Children. Cassell & Co., London and New York.

This is one of Messrs Cassell's series of Clinical Manuals, and does credit alike to author and publishers. The book is profusely illustrated and will be found a most useful guide to the diseases on which it treats. The author does not lay claim to having produced an exhaustive treatise, his design being to compose a "complete monograph" alike useful to practitioners and students. In this we may safely say that Mr. Owen has succeeded. The

advice "How to bring up infants" is singularly judicious and free from all attempts to make the infant stomach a sort of experimental ground for the numberless "patent foods" that meet the young and inexperienced mother on every hand. We commend the perusal of Mr. Owen's manual to the junior members of the profession, and we are sure that they will find the book a safe guide to the diseases of those who form a large percentage of the patients attended in the daily routine of practice.

**THE YEAR-BOOK OF TREATMENT FOR 1885.** A Critical Review for Practitioners of Medicine and Surgery. Philadelphia: Lea Bros. & Co.

The object of this work is to present a review of all the most important advances made in the treatment of disease during the past year. Each department has been dealt with fully and concisely, and the contributors are among the foremost men in the profession. The medical literature of all countries has been laid under contribution.

**POST-MORTEM EXAMINATIONS, with Especial Reference to Medico-legal Practice.** By Prof. Rudolph Virchow, Berlin. Translated from the Fourth German Edition. Philadelphia: P. Blakiston, Son & Co. Price \$1.00.

We commend this work to the attention of the profession. It would be well if all post-mortems were conducted on the lines laid down in this guide-book.

**NOTES ON DISEASES AMONG THE INDIANS FREQUENTING YORK, HUDSON'S BAY.** By Percy W. Matthews, M.R.C.S., Eng., M.R.C.P., Lond., LL.D., Medical Officer Hudson's Bay Co., etc. Montreal: Gazette Printing Co.

**A TEXT-BOOK OF NURSING FOR THE USE OF TRAINING SCHOOLS, FAMILIES AND PRIVATE STUDENTS.** by Clara S. Weeks, New York Training School. D. Appleton & Co.

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### Births, Marriages and Deaths.

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On the 28th of February, Dr. G. W. Gunter, of Middleton, N. S., aged 58 years.

On the 15th ult., Dr. John McKelcan, of Hamilton, aged 82 years.

On the 11th ult., Dr. H. T. Gilbert, of Georgetown, N.B., aged 57 years.

# THE CANADA LANCET.

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CRITICISM AND NEWS.

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## Original Communications.

### NEW METHOD FOR THE RELIEF OF RUPTURED PERINEUM.\*

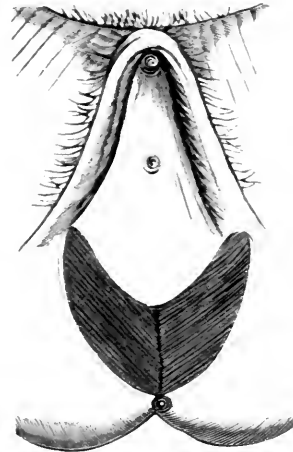
BY E. H. TRENHOLME, M.D., B.C.L.

Prof. of Gynecology, Bishop's College, Montreal.

This disease must be as old as parturition itself, and yet, beyond the adjustment of the parts by binding the knees together, in recent cases no really successful advance had been made for its cure till the late ever-lamented Dr. Sims introduced his silver suture. The operations of Baker Brown, and others, were not of any real value, and perhaps the cause or nature of failure was not fully brought out till Emmet's paper upon this subject was given to the world. Now, I do not propose to go over the many points connected with this trouble and the operations attempted for its cure. How much progress has been made can hardly be conceived of by those who have graduated during the last twenty-five years. One of the best and most esteemed surgeons of this City of Montreal, and, I might say, of this country, endeavored to dissuade a confrere from attempting the operation, stating that "it was sure to be a failure." Not only did he do this, but used his endeavors to prevent the lady from having the operation performed. Thanks, however, to the silver suture and the courage of the operator, the operation was successfully performed and the patient cured. This, occurring in our good city, speaks volumes. For my own part I think the evils resulting from severe lacerations are very great, and if anything, I may say, will direct more attention to the prevention of these evils, I will be satisfied. I feel confident that the sum-total of the sorrow and misery arising from this cause vastly exceeds our concep-

tion. It is a recognized factor in the causation of subinvolution of the vagina and uterus, and I am persuaded its results are not limited to these organs, but that the tubes and round ligaments share in the same mischief. It is a fruitful cause of retro-laxations of the uterus and prolapsus of the bladder.

Of all the marital misery and personal distress I need say nothing—these, of course, vary with the peculiarities of individual cases and the extent of the disease. I will not speak of the well known preparation of the patient required, especially in extensive lacerations: you all know as to this and the after-treatment also. There is one remark I wish to make as to what is known as the perineal



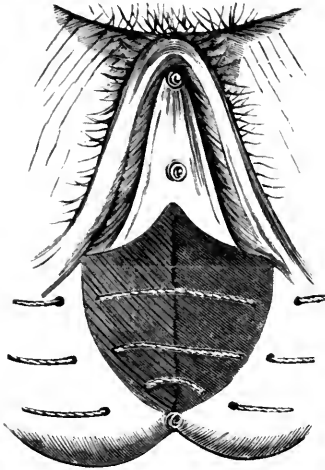
No. 1.

body. Some writers have made light of its existence, because its anatomy and relations are not sufficiently definite to merit, as they think, this appellation. That every uninjured perineum has such a body is unquestionable, and the restoration of this body is *the one* object of perineorrhaphy.

An operation is successful or unsuccessful, according as to whether this end of the operation is or is not attained—without it the natural support of the pelvic viscera is impossible—not only is there apt to be hernia of the anterior rectal wall, but prolapsus of both bladder and uterus—and this in the order I have given them. The best success, heretofore has followed Emmet's operation. His conception of the trefoil character of the surfaces to be brought together, is based upon a right conception of the anatomy of the parts. The perineal

\*Read before the Medico-Chirurgical Society, Montreal, April 2, 1886.

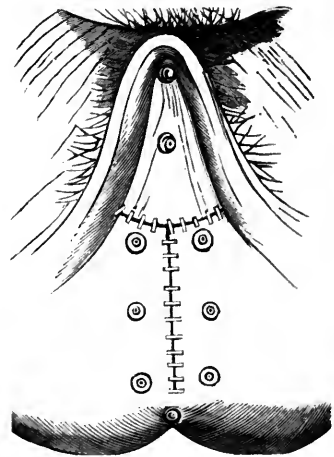
body being the central, and the lateral surfaces the outside leaves of the trefoil—each sulcus represents the lateral borders of the vagina and rectum. Perfect union of these surfaces leaves but little more to be desired. What remains to be attained is the object of what I now offer. In



No. 2.

the first place, the loss of any tissue is to be avoided, and sure union by first intention, the desideratum to be attained. My operation is based upon the recognition of the immense value of the perineal body. I denude the surfaces to the fullest extent of the parts injured. This denudation is accomplished by the removal of the covering of the parts to be denuded in the cicatricial surface in *one* piece. For this purpose the first incision is made at the upper part where the edge of the skin coalesces with the cicatricial surface—the dotted line in sketch No. 1 shows this—the knife is entered at the highest point on the right side, and the incision brought down to the lowest part of the fourchette, when it is met by a similar incision on the left side. The lowest part of the angle is then seized with the forceps and carefully dissected upward, taking special care to remove the whole surface without incising the flap—this dissection is carried on till the surface represented by the original wound is uncovered. This flap, when raised with the hook, is seen in drawing No. 2. The next step is the introduction of the sutures, (which should be of catgut, as they cause very little irritation and usually come away in 6 or 8 days) and upon this point I would say a word in favor of the use of the clamp shield suture,

which I adopt. It is by far the best one. This is because it gives the greatest possible extent of surface to surface—much greater than can be secured by any other means. Two deep sutures usually suffice, and these—whether silver, silk, or catgut—are passed in and secured by clamped shot upon an ivory shield. The first suture should be inserted low down, and about  $\frac{3}{4}$  of an inch from the edge of the wound. It must be passed under the denuded surface so as not to appear, and brought out on the opposite side at a point corresponding to that of insertion. The second deep suture is similarly introduced higher up—the last deep suture should catch the flap, and the interrupted suture will do for this. The edges of the wound are coapted by horse-hair sutures, while the upper part of the flap on the right and left side are secured by the running catgut suture—this leaves the united surfaces in the shape of the letter T. The vaginal surface of the wound is perfectly covered, and in no way can a drop of fluid enter the wound or interfere with union by first intention. There is very little pain, inasmuch as the deep sutures are clamped and allow of distention. Interrupted sutures should not be used. Where the rupture extends into the rectum the flaps are carefully brought together by running catgut suture, and the operation completed as in this case.



No. 3.

The objection felt to all former modes of operating was that it left the vaginal incision open, which sometimes therefore interfered with union by first intention. This, by my method, is now impossible, and when catgut is used the results of the operation

leave absolutely nothing more to be desired. The following points are gained 1. perfect union, 2. perfect restoration of the perineum, 3. no loss of substance, and 4. no after fever worthy of the name. Sketch 3 shows the condition of the parts at the completion of the operation.

## TETANUS FROM TOOTH EXTRACTION RECOVERY.

BY A. C. GAVILLER, GRAND VALLEY, ONT.

On the 26th March, W. P. —, at 30, called at my office to have a tooth extracted. The tooth was the first molar in the lower jaw, right side. He stated it had been aching for two weeks, and he thought it was ulcerated. He said he had slept very little for several nights previous, owing to the pain: and otherwise expressed himself apprehensive of the result. Upon adjusting the tooth for forceps and tightening my hold I found the tooth was extremely tender, and upon attempting to draw the tooth, the patient moved his head, thereby causing the forceps to slip, breaking the tooth, one root remaining firm in the socket, the front root coming half out, when the tooth broke leaving the root in a twisted position, pointing outwards, but still quite firmly fixed in the socket. The patient appeared to suffer intense pain, and drew his breath in deep, violent and spasmodic gasps. He also complained of stiffness in his hands, especially the right, and I now perceived that the fingers and thumb, though quite straight, were drawn together at the extremities and appeared to be quite stiff so as to oppose all motion, either voluntary or passive, as though partially frozen. On trying to open his hand the resistance was similar to that in a muscular cadaver during the rigor mortis. He also complained of a similar stiffness in his feet. With a fresh pair of forceps I extracted the root which was raised in the socket, after which he said the pain in the head was much easier, but the stiffness of his hands and feet did not abate. The tooth was extracted at 1 p.m. A gentleman who happened to be in my surgery, and myself, hastened to apply vigorous friction to the affected hands and feet, with decided improvement, so long as the friction was continued, but on ceasing the friction, the stiffness advanced rapidly up the arms and legs, invading the muscles of the chest, causing ex-

remely labored respiration. I administered chloroform at 1.25, but it did not appear to arrest the rapidly advancing rigidity, while the irritation of the vapour on the lining of the bronchial tubes excited spasmodic contraction of the bronchial muscular fibres, so that respiration resembled that of a typical case of asthma. As these means failed, I administered ether, one drachm in three drachms of alcohol, diluted with water, and injected  $\frac{3}{4}$  grain of morphia, while vigorous friction with whiskey was continued on the patient's limbs, which, despite our utmost efforts were rapidly becoming more rigid. The friction undoubtedly retarded the progress of the spasms as the patient expressed himself feeling better and having less stiffness in the limbs when the friction was freely applied. The character of the spasms was throughout, one of tonic rigidity with exacerbations. An exacerbation would commence in the hands and feet and rapidly travel up the limbs in a wave-like manner toward the trunk. In the trunk the muscles of the back were principally affected. The neck also was drawn forcibly backwards, which, together with the contraction of the muscles of the back, gave the typical appearance of opisthotonos. During two of the exacerbations respiration was entirely suspended, owing to the complete rigidity of the muscles of the thorax, so that the patient lost consciousness by apnoea. The heart also appeared to be implicated by the spasm, as the pulse ceased to beat during the acme of his most violent attack, in which his hands were so firmly clenched that an assistant who was engaged in rubbing one of the patient's hands—felt his hand almost crushed by the vice-like contraction of the patient's fingers. Another assistant, a powerful and heavy man, was lifted off his feet by a spasm affecting the lower limbs. At this time, about 2 p.m., the rigidity invaded the muscles of the jaws so that they were several times firmly locked, while the patient remained perfectly conscious. During the remissions, the patient complained of numbness and stiffness of the hands and feet and in a less degree of the legs, with stiffness of the jaws; but with these exceptions, throughout the whole attack, the patient's senses were perfectly clear and his mind collected, except when almost suffocated by the extreme rigidity of the muscles of the thorax. The spasmodic contraction affected the muscles of the eye to such an extent that the

cornea was frequently completely invisible, from extreme rotation of the eye-ball. At 2.30 the pupil was much contracted by the morphia, but the spasms were yet at their height. I, therefore, again had recourse to the morphia, believing that my only chance of success lay in deadening the nerve-centres before the circle of vicious reflex action became fully established. Whilst charging my hypodermic syringe the patient had so severe an exacerbation that my assistants, with one exception, pronounced him dead, some leaving the room. I immediately injected  $\frac{1}{4}$  grain of morphia partly in the temple, and the remainder in the forearm: both of which parts were immediately subjected to powerful friction. The injection took effect rapidly and the spasms shortly began to abate, and by 3.15 had entirely ceased. The parts last affected were the muscles of the little fingers. No sooner had the rigidity ceased, than the patient sank into a somnolent condition. Those functions, which, during sleep are continued by reflex action, appeared most affected, for while his sleep was yet light, his respiration entirely ceased, so that when I re-entered the surgery, after an absence of a few moments, I found his features livid, his pulse almost imperceptible, and no visible respiratory movement. I immediately called him loudly by his name and he readily awoke and sat up, but shortly lay down and relapsed into the former condition of light sleep, his respiratory movements being very slight and gentle, and diaphragmatic, but not at all slow. In this condition he continued, gradually becoming more wakeful. At 7 p.m. he complained of occasional twitching of the muscles of the arms and shoulders, which, probably, was at least in part due to the action of the morphia, which I have observed to produce similar effects in other cases. For this twitching Dr. A. Groves, of Fergus, in whose care I had left him for a short time, administered one drachm of pot. brom., and advised a similar dose at midnight, which was given. The bromide speedily relieved the twitching. Several assistants watched the patient through the night. About 2 a.m. he was observed to fix his eyes on certain objects, and extend the fingers of his right hand in a very peculiar manner. I prescribed  $\frac{1}{3}$  grain morphia per orem. After this he slept gently until half-past five, when his breathing suddenly became very faint, and his pulse almost imperceptible. My assistant found

it extremely difficult to arouse him, but after shaking him vigorously and speaking loudly to him he roused up, and when I saw him a few moments later I found him easy to arouse, and his respirations of ordinary rapidity; but entirely diaphragmatic and of small amplitude. I think, when the  $\frac{1}{3}$  grain of morphia was administered at 2 a.m., patient was still influenced by that, which had been given the previous afternoon, and that  $\frac{1}{6}$  grain would probably have been a preferable dose. During the next three days he gradually regained strength, although it was some days before he could fully open his mouth. The jaws did not seem stiff, but the mouth opened only so far and then came to a full stop. Movement was free so far as it went. I did not permit him to leave my surgery until twenty-six hours after the final disappearance of tetanus, neither did I allow him any solid food. When he awoke on the fourth morning, he found the third and fourth fingers of the right hand firmly flexed on the palm, so that it required some time and friction ere he could extend and move them freely. He also felt very nervous and shaky, and complained of palpitation of the heart. I therefore prescribed the following:

R Tr. Cinch. Co. . . . .  $\frac{5}{8}$  i.  
 Pot. Brom. . . . .  $\frac{5}{8}$  i.  
 Tr. Digital. . . . .  $\frac{3}{4}$  ii.  
 Aqua. Ad. . . . .  $\frac{5}{8}$  viii.  
 S.— $\frac{5}{8}$ ss. ter. in die. —M.

From this time he rapidly improved, and when I last saw him, April 2nd, he expressed himself as being in his usual state of health.

### FIBRO-CYSTIC TUMOR OF UTERUS AND OVARY—OVAROTOMY—RECOVERY.

BY K. N. FENWICK, M.A., M.D., PROF. OBSTETRICS AND GYNECOLOGY ROYAL COLLEGE OF PHYSICIANS AND SURGEONS, KINGSTON.

Mrs. B. aged 36, married eleven years; no children; no miscarriages; always regular. About eight years ago first complained of pains in the abdomen, and was informed by her physician that she had a tumor. About two years ago she moved to Kingston, and upon examination I found a tumor in the right side of abdomen about the size of a child's head, hard and evidently containing fluid. At that time there were no indications of its fibrous character, and I had the impression that it was

ovarian, but as the symptoms were not urgent an operation was not suggested. She soon after this left Kingston and moved to Carlton Place, where the tumor rapidly became larger, and as the pain, distension, and vomiting became very troublesome she was tapped to give temporary relief. The cyst very rapidly refilled, and four weeks afterwards the symptoms becoming very distressing she came to Kingston General Hospital to have the tumor removed.

On admission she was hardly able to retain any food; the abdomen was very fully distended, tense, and marked by veins; she suffered constant pain in her side; and her face had an expression of hopeless anguish.

On the 21st of April, 1886, the room being heated to 80°, and with strict antiseptic precautions, bichloride of mercury being the agent employed, and assisted by Dr. Stirling, and Messrs. Errett and Robertson, medical students, I proceeded to operate. The spray was not used.

An incision was made four inches in length, from below the umbilicus towards the pubes in the median line, cutting the tissues in order upon a director until the peritoneum was reached, which was carefully cut in the same way. A sound was then introduced and passed all round the anterior and lateral walls to feel for adhesions, but these were slight and easily freed. She was then turned upon her right side and the cyst punctured with a curved trocar and sixteen quarts of a greenish-yellow fluid removed, the cyst walls being gradually drawn out, and a solid mass as large as two fists which again was found to be attached to the whole of the upper border of fundus of uterus and the right broad ligament. An endeavour was made to tie this broad pedicle with silk in sections, but as it was found to be useless this was tied and left in. The pedicle then consisting of uterus and broad ligament, fully eight inches wide, was sewed with silver wire, using the cobbler's stitch as recommended by Emmet. The cyst walls and solid mass were then cut away about an inch from this, and as there was still a good deal of oozing from the stump it was held up to the wound by the fingers and seared thoroughly with the thermo-cautery, and then as it still bled it was swabbed with perchloride of iron, and dropped into the pelvic cavity. The abdominal cavity was then carefully sponged out, the edges of the peritoneum sewed up with a

continuous catgut suture, finally including the rest of the wound. Collodion, iodoform gauze, bichloride gauze, absorbent cotton and a bandage completed the dressing. No drainage tube was used. She suffered severely from shock for a few hours, but soon recovered, and the next day her pulse was 120, temp. 100° and resp 33. Her condition remained about the same until the 8th day, the vomiting having ceased since the operation, and having no pain whatever nor even tenderness over abdomen. Her diet for forty-eight hours consisted simply of iced brandy, and then she was allowed milk and limewater, and for a week milk and brandy only.

The wound was dressed on the 8th day and found perfectly united without a drop of pus. On the evening of the 8th day her temperature went up to 105°. On examining the wound there was found a little gaping of the skin in the centre and some bloody serum oozed out, but it had no smell, and after washing it out with bichloride solution it ceased. During the next few days the skin gaped a little but the deeper parts were perfectly healed and the outer part of the wound was closed with adhesive plaster.

Quinine in 10 gr. doses was given in capsules twice a day, and the temperature then came down to 101° and hardly ever rose higher, and about the 19th day after the operation it became normal.

About the 9th day she had diarrhæa which continued more or less for several days, but was kept in check with starch and laudanum injections, and also by sulphate of iron, and lactopepsin in capsules.

On the 20th day she sat up for the first time and was allowed to have full diet, since which time her recovery has been uninterrupted, leaving for home on the 17th May in good spirits.

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## Correspondence.

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### ONTARIO MEDICAL ASSOCIATION.

To the Editor of the CANADA LANCET.

SIR,—In common with many others, I am glad to note that an effort is being made to get the members of the profession in Eastern Ontario to take more interest in the success of the Association, and to manifest that interest by attending the meetings with more regularity. I sincerely hope the effort will be successful, and that this year the wise men from the east will appear in

greater force at the coming meeting at Toronto in June. You will pardon me, I trust, for mentioning one matter which I have frequently heard spoken of, and that is, that in the management of the affairs of the Ontario Medical Association the men from eastern Ontario seem to be somewhat slighted. This may never have been done intentionally. However, while the Association has been in existence now nearly five years, and a new President has been chosen each year, no one east of Toronto has ever been selected for that honorable position. It is true that each year some eastern man is selected for vice-president, but at the close of the year, instead of being promoted to the presidency he is retired and another chosen for the vacant position. Some of us think that when a man has been selected as vice-president, he should, before being retired, be allowed to have the honor of the presidency. I am glad to learn that some who take a prominent interest in the Association have stated that the present vice-president from eastern Ontario will likely be selected president for the ensuing year. If this is the case I am sure no one will express or have reason to feel the slightest dissatisfaction. One more suggestion and I will stop. Let some effort be made to suppress the paper fiend—I mean that individual who turns up at every meeting with a paper or something which he must read, and although no one but himself thinks his production is a clever one, yet he seems to think it necessary to take up valuable time which might better be devoted to interesting discussions on the different reports. These discussions always bring out the views of some of the best medical men in the Province, and are most instructive to the oldest of us. The Association should not be divided into sections for this divides the interest, and usually the room of one section is full while that of the other is almost deserted. Perhaps these suggestions will do no harm.

Yours, OLD SCHOOL.

### Selected Articles.

#### CONTRIBUTIONS TO PRACTICAL SURGERY.

BY PROF. JOHN CHENE, ED.

*Hernia.*—In old people with long standing hernia the curative action of a truss cannot be looked

for; but in all recent cases at all ages a truss must be applied, not simply as a palliative, but in order to effect a cure. The younger the patient, the greater is the probability of this good result. The hernial protrusion, after it has once been reduced, should never be allowed to come down again. Although in the recumbent posture the chances of the hernial protrusion occurring are diminished, still, as any exertion, as in the act of coughing, may during the night cause the protrusion, a truss should be worn day and night. During the night less pressure is required to keep up the hernia, and if a spring truss is irksome to the patient the hernia may be kept up by a thick pad of layers of lint or layers of flannel, fixed in position by an elastic spica bandage.

(a.) In inguinal hernia a double spiral truss is preferable to a single-headed truss. In young children the presence of an inguinal hernia on one side indicates a tendency to hernia on the opposite side; in the adult the same factor is at work, although in a less degree; for this reason the use of the double-headed truss is indicated. A double-headed truss also fits more comfortably, and gives that general support to the lower part of the abdominal wall which renders the patient infinitely more comfortable than if he used simply a single-headed truss. In inguinal hernia care must be taken that the pad of the truss does not press on the spine of the pubis. In the oblique variety the principal pressure should be over the situation of the internal abdominal ring, and the head of the truss should not extend to a lower level than immediately below Pourpart's ligament. Otherwise, when the patient stoops, the tissues of the thigh, pressing on the lower part of the head of the truss, are apt to displace it in an upward direction and render it inefficient, the hernia escaping below it. Although in some rare cases a perineal band may be necessary, every endeavor should be made to avoid its use, as it is irksome. The wearing of a piece of boracic lint below the pad of the truss prevents chafing and irritation of the skin, and the parts are kept dry, the presence of the lint allowing of free evaporation. The pad must be flat and have no tendency to press into the inguinal canal. All that is required is to support the weakened wall, and any pressure into the canal tends to weaken by atrophy the structures which form its walls, and in this way to prevent a radical cure. Everything should be done to imitate Nature's way of curing a hernia, namely, by contraction of the neck of the sac and contraction of the fascial structures which surround the neck of the sac. The surgeon should see to the application of the truss himself. The weaker the truss the better, as long as it fulfils its object, keeping the hernia up. Each time the hernia is allowed to come down the tissues are stretched. The good work of weeks is undone by a single protrusion, and hence the im-



portance of explaining to the patient the necessity of never allowing the hernia to come down.

(b.) In umbilical hernia the natural tendency to contraction of the abdominal opening is interfered with if a nipple-shaped pad is used. The pad must be flat, of a considerable size and thickness, and in the child it is best kept in position by the use of a broad elastic bandage. If the pad is made of layers of flannel, it should be placed next the skin, under the chemise; the elastic roller is then passed round the body over the chemise, and a large safety-pin is passed through the bandage, chemise and pad, fixing the last firmly in position.

(c.) In femoral hernia the great depth of the crural ring through which the hernia protrudes prevents pressure being made directly upon it, and in this form of hernia the use of a small nipple-shaped triangular pad, fitted on to the ball and socket joint of the Salmon & Ody truss, as first recommended by Prof. Spence, is the most efficient means of keeping up the hernia. By the judicious use of what is termed a keeper, the lower extremity of the pad can be tilted upwards and backwards, increasing the efficiency of the appliance. In some cases of inguinal hernia, instead of the fixed head, the Salmon & Ody ball and socket pad arranged with a keeper may be found useful.

(d.) A hernia, apart from strangulation, is irreducible either in consequence of adhesions of the omental contents to the inner surface of the sac wall, or in consequence of induration and chronic enlargement of the omental contents after they have passed into the hernial tumor. In the former case, in order to reduce the hernia, a cutting operation will be necessary, opening the sac, dividing the adhesions, and returning the contents. In the latter case, namely, where there is induration with thickening of the omental contents, the reduction of the hernia is generally effected by prolonged treatment in the recumbent posture, the foot of the bed being elevated, and the patient kept on low diet. Some years ago the writer had under his care a patient with a large irreducible inguinal hernia, in whom repeated attempts had been made to reduce the hernia by the methods indicated above. In that case, the continuous use of elastic pressure over the whole surface of the inguinal tumor, by means of an elastic bandage, enabled him to completely reduce the hernia after three days of continuous pressure. Since that time several cases of irreducible inguinal, femoral and umbilical hernia have been treated in this way with most satisfactory results; and in every case of irreducible hernia this method should receive a fair trial before cutting down and relieving the irreducibility by operation.

In the reduction of an inguinal hernia the mobility of the neck of the sac, where the constriction exists, is a great obstacle to reduction. It is therefore necessary to fix the neck of the sac with

one hand before applying pressure over the hernial tumor with the other hand. If the hernia is of large size, the reduction is often facilitated by getting an assistant to fix the neck of the tumor, the surgeon applying pressure with both hands over the hernial mass.

In femoral hernia it is impossible to fix the neck, and, although the anatomical relations here render the neck of the sac less mobile than in inguinal hernia, still the impossibility of grasping the neck during taxis is in all probability the main reason why taxis fails more frequently in femoral than in inguinal hernia. The pressure in femoral hernia is mainly on the apex of the tumor, and as the effect of pressure is often simply to change the shape of the tumor, its reduction is not effected. In inguinal hernia the neck of the sac can be fixed, and the pressure can be applied over the surface of the tumor in a more efficient manner.

(e.) When a hernia is strangulated, that is to say, when there is an obstruction to the blood-flow into and out of the hernial tumor, if taxis fails, there should be no delay in operating. It is often a very difficult matter in practice to distinguish a strangulated hernia from an inflamed hernia, in which there is no inflammation of the contents of the hernial tumor apart from strangulation. It is also difficult to diagnose a strangulated hernia from an obstructed hernia, in which there is an obstruction to the free passage of the contents of the bowel within the hernial sac. In the first case it is a local peritonitis, in the second a local constipation. Both conditions, if they persist, end in strangulation. When the surgeon is in any doubt, he should operate. In all cases in which there are any symptoms which may be referable to a strangulated hernia, a careful examination by sight and touch must be made of all the situations in which a hernia may exist; and if in any of these situations a swelling is discovered, however unlike it may be to a hernial tumor, the surgeon should cut down upon the swelling, and carefully examine its exact nature. He may find, for example, only an inflamed gland, or he may find a small hernial tumor behind an inflamed gland. In the former case no harm has been done: in the latter case delay would probably mean a fatal result. Do not be deceived by a free passage of the bowels after the symptoms of strangulation have commenced. In women more particularly, two or even three free movements of the bowels may take place after complete strangulation. The bowels being loaded with fecal matter, the passage of this fecal matter per anum deceives the surgeon, and he delays operating until it is often too late. After operating, relieving the constriction, and returning the contents, ligature the neck of the sac, and stitch together the structures which surround the neck—perform, in other words a double operation: firstly, relieve the strangulation; and, secondly,

attempt to cure permanently the tendency to the formation of a hernia. In performing the radical cure, therefore, either after the operation for strangulated hernia, or after operating on an irreducible hernia which has resisted carefully applied elastic pressure, or after operating on a reducible hernia which cannot be kept up by a truss, imitate Nature's method of cure,—ligature with catgut the neck of the sac, and stitch together the anatomical structures which surround the neck of the sac.

*The Rectum*.—In all rectal affections there is often great depression of spirits. There is a close physiological connexion between the genito-urinary tract and the rectum. Very frequently a patient will come to you complaining of irritability of the bladder, which may be due to some rectal irritation, *e. g.* piles or fissure; and it is, therefore, a good rule in all cases of irritable bladder to make a careful examination of the rectum, anus, and perineum. In all rectal examinations care must be taken to ascertain before making the examination that the patient is not suffering from acute syphilis. The discharge from an ulcer when the patient is in this state is infectious. In an examination of the prostate it is best to place the patient on his back; but in an examination of the posterior rectal wall the patient is best lying on his left side. In the married female, the surgeon with two fingers introduced into the vagina can by pressure cause protrusion of the mucous membrane of the rectum, and in this way assist the diagnosis in cases of fissure and of internal piles. The best way, however, of examining a male patient is to make him lean over the back of a chair. If the buttocks are then separated, much may be learned by a visual inspection of the perineum. If there is any discharge the skin of the perineum will be more or less excoriated, the area of excoriation corresponding to the portions of skin in apposition with each other. If there is a fissure, the opening of the anus will be firmly closed by the contraction of the sphincter, and the patient shrinks from any tactile examination. One small external pile is often an indication of the presence of a fissure at its base. A venous pile, due to the rupture of a small vessel at the junction of the skin and mucous membrane, will be indicated by a bluish colored projection at the seat of the rupture. A redundancy of the folds of skin around the anus indicates in all probability the presence of internal piles within the opening. A leathery appearance of the skin around the anus is seen in the affection termed *pruritus ani*. After a careful visual examination the finger well oiled is to be introduced gently, and with a rotatory movement into the cavity of the rectum. In some rectal conditions associated with an abnormal dryness of the mucous membrane in the narrow part of the canal corresponding to the internal sphincter, this dryness will be best overcome by the injection of an ounce of warm oil before attempting

to introduce the finger. After the finger is fairly within the rectum, inflammatory affections of the mucous membrane will be indicated by increased heat within the rectum. The presence of a fissure will be discovered as the finger is being introduced. Some fissures lie immediately within the opening. In this case the lower extremity of the fissure will be observed by forcibly separating the buttocks, and stretching the skin around the anus. In other cases the fissure lies altogether within the opening, and can only be diagnosed by feeling it with the finger. An anal speculum may be used in doubtful cases, but the educated finger is the best diagnostic. The condition of the prostate is carefully to be noted: (1.) With regard to its size and its shape, increase in size of one or other of the lateral lobes indicating lateral hypertrophy of the gland. (2.) As to the presence of a soft point or points, indicating either inflammatory abscess or tubercular deposit in the process of disintegration.

In the examination of a fistula with a probe, the finger in the rectum will enable the surgeon to discover more easily the internal opening. In stricture of the rectum the stricture is almost always within reach of the finger, and the condition of the stricture can be carefully examined. After the finger is removed the presence of pus or slimy blood-stained mucus will indicate the existence of an ulcerated surface. Diarrhoea is often a symptom of stricture of the rectum, and in anyone above middle age who suffers from persistent diarrhoea a rectal examination should always be insisted upon in order to assist the diagnosis.

## DIFFERENTIAL DIAGNOSIS OF HEPATIC DISEASES.

Dr. W. E. Quine (*Western Medical Reporter*): The diagnosis of a disease of the liver is accomplished by comparing, successively, each group of symptoms known to be characteristic of a disease of the organ, with the group presented to our patient, and then deciding which of the former fits our case. The presence of jaundice is a prominent feature of some groups, while its absence from others is equally noticeable. Hence its presence in any case of disease before us, limits the process of comparison to those diseases whose symptomatic groups contain it. The same may be said of other striking symptoms, such as pain, ascites, enlargement of the affected organ, etc.

Consider the diagnostic relations of jaundice first:

1. Remember that its absence is not proof of the absence of hepatic disease.
2. Intense jaundice, clay-colored stools, and a distended gall bladder, indicate obstruction of the common duct.
- 3.

Jaundice, preceded by a history of severe pain, is of calculous origin, and due to obstruction of the common duct. 4. Jaundice, associated with an antecedent history of similar attacks, points to gastro-duodenal catarrh, or to biliary calculi, as the primary morbid state. 5. If it occur suddenly, in apparent health, it is due either to obstruction of the ducts, or to emotional disturbance. 6. If it appear slowly, yet progressively, it is due either to stricture, or to compression of the common duct. Stricture usually has an antecedent history of biliary colic, and compression is often associated with a discoverable tumor. 7. Slight but persistent jaundice is due either to incomplete obstruction of the biliary ducts, or to passive congestion of the liver. Passive congestion depends on some thoracic obstruction to the circulation, either disease of the heart, or disease of the lungs. 8. Very slight jaundice, associated with an abnormally small liver, indicates sclerosis of the organ. 9. Jaundice, associated with enlargement of the liver, is, in acute cases, of catarrhal origin; and in chronic cases it is usually due to cancer, but occasionally due to hypertrophic sclerosis. It occurs in over fifty per cent. of the cases of cancer. 10. If jaundice be attended with fever, it is due either to gastro-duodenal inflammation, or to inflammation (infective) of the portal vein; or it is a complication of some specific febrile disease. 11. Jaundice, associated with ascites, indicates either cancer or sclerosis. In cancer the liver is abnormally large, and in sclerosis it is abnormally small. In cancer, ascites occurs in seventy-five per cent. of the cases. 12. Jaundice, associated with cerebral disturbance, indicates either acute thoracic inflammatory obstruction to the circulation, or specific febrile disease; or, in very rare cases, acute yellow atrophy of the liver. 13. Jaundice is not a characteristic symptom of hepatic abscess, waxy degeneration, fatty infiltration, or hydatid tumor of the liver, though it may occur in any of these diseases.

Consider now the diagnostic relations of some other prominent symptoms of hepatic disease:—

1. Enlargement.—This is marked, and symmetrical, in amyloid degeneration, and sometimes in passive congestion; marked, but symmetrical in cancer, hydatid tumor, and in ninety per cent. of the cases of abscess; symmetrical, but not marked, in congestion (ordinarily), acute biliary obstruction, fatty, and pigmentary infiltration, and hypertrophic sclerosis. 2. Enlargement and Jaundice.—These conditions co-exist in cancer, obstruction of the bile ducts, passive congestion and pigmentary infiltration. Jaundice is marked in fifty per cent. of the cases of cancer, and in all cases of biliary obstruction; but in passive congestion and pigmentary infiltration, it is usually slight. 3. Enlargement, Jaundice, and Ascites.—The conditions co-exist in cancer. 4. Shrinking and Jaun-

dice.—Occur in acute yellow atrophy. 5. Shrinking and Ascites.—Occur in sclerosis. 6. Fever.—In acute yellow atrophy, the temperature of the body is 100° or over; and in hepatic abscess there is usually an obscurely periodical fever, of variable intensity, associated with much sweating. 7. Emaciation.—It is rapid in cancer, and usually in abscess; and slow in cirrhosis. 8. Hemorrhagic Tendency.—It is very marked in acute yellow atrophy. It often exists in cases of chronic jaundice and anemia depending on cirrhosis, cancer, and pigmentary infiltration. 9. Cerebral Symptoms.—They are striking in acute yellow atrophy, and in advanced pigmentary infiltration.

Finally, let us consider the diagnostic features of the important diseases of the liver and biliary passages:

1. Catarrhal Jaundice.—Begins with symptoms of gastro-duodenal catarrh: the jaundice lasts two or three weeks, and is associated with some enlargement of the liver and local discomfort: the stools are clay-colored, and sometimes the gall-bladder is noticeably distended. 2. Obstructions, Cystic Duct.—Here there is a pyriform tumor, but there is neither jaundice nor clayey stools. 3. Obstruction, Hepatic Duct.—No tumor of the gall bladder; decided jaundice, and depending on the seat of obstruction, the stools may be clayey, or of normal coloration. 4. Biliary Colic.—Usually comes on two or three hours after a meal, or immediately after vigorous exercise; calculi appear in the stools; jaundice occurs within a day or two. There is no evidence of intestinal derangement (colic); no stercoral vomiting (intestinal obstruction); no pyuria or hematuria (renal colic). 5. Passive Congestion.—There is either disease of the heart, or obstructive disease of the lungs: the liver is large, sometimes very large, firm and tender; sometimes there is bilious vomiting and purging, and also slight jaundice. 6. Sclerosis or Cirrhosis.—Nearly always a history of intemperance, constitutional syphilis, or chronic biliary obstruction ("biliary cirrhosis") precedes it: onset insidious; course, three months to six years. The liver is small; dyspeptic symptoms are associated with ascites, and prominence of the epigastric veins. 7. Amyloid or Waxy Degeneration.—There is a history of profuse suppuration, or of syphilis or tuberculosis without suppuration. Liver is large, smooth, and hard; spleen also: there is albuminuria; late, the gastro-intestinal canal becomes irritable; general health impaired; course of the disease is slow. 8. Fatty Infiltration.—Liver is large, smooth, soft, and its edges are rounded. Dyspeptic symptoms usual; also symptoms of heart failure. Without the latter, diagnosis cannot be made. 9. Pigment Infiltration.—Always associated with a history of chronic malarial infection. At first the liver is enlarged, but later it shrinks. Symptoms of gastro-intestinal catarrh

occur, and they are associated with bronzing or pigmentation of the skin, a hæmorrhagic tendency, headache, tinnitus, vertigo, delirium, and involuntary discharges. 10. Cancer. — The cancer is secondary in fifty per cent. of the cases, to cancer of the stomach, rectum, etc. Sometimes there is a history of heredity. Cachexia occurs; rapid emaciation and impairment of health; anæmia and a hæmorrhagic tendency; jaundice in fifty per cent. of the cases; ascites in seventy-five per cent. of the cases; the liver enlarges rapidly, but irregularly; there is lancinating pain. 11. Hydatid Disease.—Results, usually, from close association with infected dogs. The health is undisturbed, unless pressure effects of the tumor derange it. The liver is the seat of a great, irregular, painless tumor, which *may* exhibit “hydatid fremitus” when percussed. In case of doubt, aspirate. The fluid is non-albuminous, and it contains “scolices.”

### THE DIETARY IN INDIGESTION.

BY J. MILNER FOTHERGILL, M.D., EDIN.

When I hear medical men denouncing a regulated dietary in indigestion, my surprise is excited. Is it a malady to be combated by drugs only? I do not think anyone will support that proposition. Medicinal agents are not without their value; but the medicinal treatment of indigestion is surely but ancillary to the dietetic management. That a regulated dietary is too often a restricted dietary—so restricted indeed that the patient is practically half-starved—may be admitted. But need a regulated dietary necessarily be a very restricted one? I opine not; if the matter of the dietary of the dyspeptic be given a little more attention.

And for this it is well to keep the physiology of indigestion in mind. Digestion is solution by hydration so that the carbo-hydrates and albuminoids may pass through the wall of the alimentary canal; after which they are de-hydrated—else they would pass out by the kidney, giving glycosuria and peptonuria and leaving the body unfed. But a preliminary to solution is disintegration. If mastication be not properly performed the “lumps” of food find their way into the stomach and offend it.

Pastry, pieces of hard potato, cheese, are notorious offenders. The solvent action of the gastric juice can exercise no disintegrating effect upon the substances, while they act as irritants and set up pain. A piece of meat comparatively unchewed is less objectionable because the gastric juice acting upon the connective tissue allows the muscular fibrilla to fall asunder. But even with muscular fibre there is a wide difference. Pork and veal are hard meats, and not readily falling to pieces in the stomach under the action of the gastric juice are held, and rightly too, to be indigestible. On

the other hand a thin slice of well boiled ham, cut across the fibre is very digestible. So is the loose fibre of a sheep's head. This is the mechanical aspect of the digestibility of food. Hard stringy meat is very indigestible. So are ill-cooked vegetables, and especially the cruciferae, so are hard boiled eggs.

Fish, and especially white fish, whose fibres very readily fall to pieces, are in repute with dyspeptics for obvious reasons. Fish which are fatty, are indigestible (because the fat resists the action of the gastric juice) as the flesh of the salmon, the mackerel and the herring. The short fibre of the whiting, “the chicken of the sea,” makes this fish especially digestible. Then come the flat-fishes, the haddock and the cod. They all are best boiled, for if fried, care is requisite that the flesh be not soaked in fat—when it is highly indigestible. There are few more indigestible matters than a fried sole which has not been skillfully cooked. And the same holds good of birds. Chicken and game are digestible, while the duck and goose, greasy-fibred meats are as certainly indigestible.

Potatoes have an evil reputation, but that again is largely a matter of cooking. A potato which is imperfectly cooked has a hard centre. A “stone” an Irishman calls it—and if palpable pieces of such hard indigestible matter be swallowed gastric distress is the intelligible result. But if the potato be well cooked and put through a sieve it ceases to be indigestible from “the mechanical point of view.” It is the question of disintegration which militates against vegetables, and uncooked fruit. Pieces of hard apples are notoriously indigestible; while a baked apple will sit lightly on the most irritable stomach. The flesh of the grape is in great repute in all conditions of gastric irritability and debility whether primary or secondary to some general sickness.

Fat is an offence to a susceptible stomach, even as liquid fat floating about in it; but still more as lumps of fat upon which the stomach can exercise no solvent influence. Hence many persons, children and adults, reject sweet pieces of fat, and (after the meal) take some fishy oil. As the digestion of fat does not commence till the food has left the stomach, it is not well to give fat till its “time draws nigh.” Thin stale bread with butter rubbed well in and doubled is much more digestible than the same bread cut thick with a stout layer of butter plastered over it.

Pastry, when fat and flour are well rubbed together, form a most indigestible compound resisting all disintegration except mastication. Suet puddings and dumplings also are indigestible.

On the other hand milk puddings, especially if made without an egg, are in repute, and not without reason for dyspeptics. They are light and sit easily on the stomach, the farinaceous matter being readily disintegrated, and what escapes disin-

tegration is soft and does not give offence to the stomach.

There is another matter not of occult but of microscopic disintegration, or actual solution which has yet to be discussed—a matter of vital importance. As savage man sat grinding the cereals which form so large a factor in human food, the action of the jaws produced a free flow of saliva, and as fast as the finer particles were broken off the seed, by the crunching of the teeth, diastase of the saliva converted the insoluble starch into the soluble dextrine and grape sugar. The toil of the miller produces disintegration and relieves the jaws of much of the labor. But disintegration is only the precursor of solution. The starch granule remains. By heat the cook cracks the starch granule so that the solvent diastase can readily act upon it. So far, so good; but heat does something more. It has an actual solvent action and heat will, if sufficient, cause conversion of starch into dextrine. A thoroughly well baked flour if subjected to the iodine test under a microscope will readily show this.

When a large quantity of raw unconverted starch enters the stomach it is a burden to that viscus. The gastric juice has no effect upon starch and the starch granules merely embarrass the action of the stomach until they find their way out of it by the pyloric ring—and sometimes by the way they entered, viz., the gullet. Undigested starch hampers the stomach and makes the labor of that viscus a painful toil to it. New bread is a gross mechanical irritant, resisting disintegration. The impediment caused by isolated but numerous starch-granules is another matter. Biscuits and crackers if insufficiently masticated cause indigestion. So do cakes which have not long been exposed to heat. The cakes which are held in such favor at the breakfast table in American households, have been regarded as indigestible and a glance at an American cooking book explains why. These cakes are exposed to heat for from thirty to forty minutes only. [The language of England sometimes requires translation. For cakes read rolls, and for biscuit read cracker.—ED.] A good biscuit or loaf is much longer in the oven. Potatoes are indigestible as ordinarily eaten, because they are not long exposed to heat. But if well mashed potatoes be put into the oven to brown, or be placed before the fire for that purpose, the longer exposure to heat tells upon the starch-conversion.

Hominy that is well boiled or subjected to the final heating process of cooking is decidedly digestible. Cereals that have been steam cooked are in repute with dyspeptics either for adding to meat teas, or for preparing milk puddings. Some cooks who have to cater for dyspeptics boil all their rice, sago, and tapioca thoroughly before making these up with milk for a milk pudding. In Germany,

pearl-barley, thoroughly well boiled and passed through a sieve is in request as an addition to meat teas for invalids. The porridge of Scotland being made with coarse oatmeal is boiled a long time, while in England a short boil is enough with the fine ground oatmeal in vogue there.

The advantage of the numerous prepared foods—whether babies' food or invalids' foods—which are all more or less compounds of starch which has been to a certain extent predigested either by baking or the malting process, lies in their ready digestibility. A touch of saliva is enough to complete the conversion of such carbo-hydrates and the soluble matters pass out of the alimentary canal, and the stomach is not burdened with a weight of undigested starch impeding its work.

Gross and fine disintegration of food are cardinal matters in the dietary of dyspeptics.

Mastication must be perfect else gross particles embarrass the stomach. Starch granules which have escaped the saliva interfere with the solvent action of the gastric juice on albuminoids. The dietary of dyspeptics must be conducted on the above lines; and if the dyspeptic were properly informed he could find a sufficient variety of food; but if he be told to diet himself upon a number of articles of food he soon begins to loathe them and often goes without food sooner than partake of them.

Of course there are dyspeptics and dyspeptics! Some only require to give a sufficiency of time to the process of mastication to be free from suffering. Others must eschew pastry, veal and pork. Others again have to abandon solid meat and vegetables and adhere to meat broths, with cooked starch, malt-extracts, malted preparations, milk puddings and fish. When the stomach has been outraged or offended care is requisite for its restoration. When there is present a condition of general exhaustion food will disagree which ordinarily can be taken with impunity. When a condition of acute indigestion is set up a very careful dietary for a few days is directly curative.

Ready disintegration and solubility of food constitute the base line of the dietetic treatment of indigestion.

## PESSARIES: INDICATIONS FOR. AND METHODS FOR THEIR TREATMENT.

In a clinical lecture by Dr. H. K. Leake published in the *Texas Courier-Record of Medicine* he remarks as follows upon the subject of pessaries. My method of placing pessaries, is, so far as I can learn, different from that of all others who use them. The Sims' speculum dilates the vaginal canal and reveals to the critical eye of the surgeon its whole extent, thus enabling him to perform operations within its cavity with as much ease as those he undertakes on the exposed

parts of the body. Why not utilize the same means for the perfect fitting and introduction of pessaries? For illustration, take a case of retroversion. The patient lies in Sims' position with the perineum well retracted by the speculum in the hands of a qualified assistant. The spirit lamp used in modeling your instrument burns brightly on a table at your left hand. You now introduce well into the cavity of the uterus, the Elliot or Emmett's repositor, and reversing the action of the instrument, you have the satisfaction of witnessing the organ revolve, right under your eyes, into its normal position. The repositor being now withdrawn it is replaced by the sound, the handle of which is given to the assistant, who holds the uterus in its new position, until a pessary can be fitted to the conformation of the vagina and cervix. Experience will enable you almost at a glance to determine the size and shape of the pessary required. Having heated the hard rubber over the spirit flame, its curves are unbent or increased, its fenestra widened or narrowed, or any other form given the instrument, which is desirable, before leaving it permanently in position. Resuming control of the sound, its handle is passed through the fenestra of the pessary and the latter strung along the continuity until the cervix is reached, when by tilting up the lower end, or depressing the upper bar, the latter glides readily in position up behind the cervix: after which the sound is withdrawn and the speculum removed. The patient is now made to stand erect and is subjected to a final examination. The index finger, well lubricated, being introduced into the vagina and carried up to the vault, is swept around the cervix noting the position of the pessary and effect, if any, produced upon the affected organs. This plan of fitting and introducing pessaries seems to be the most rational of any yet recommended. Indeed, I do not see how it is possible in any other way to conform the outlines of the instrument to the anatomy of the vaginal walls and cervix, and thus meet the exact requirements of each case. The same position is to be recommended also in re-examining and re-fitting pessaries, the precaution being to inspect them before removal.

All patients who have had pessaries introduced for backward displacement should be instructed in the knee-breast position advised by Dr. Campbell. They should assume this for at least five minutes night and morning. By this rational procedure the strain upon the pessary is lessened somewhat, thereby assisting its traction-lever power. Moreover, the blood, which has yet a tendency to stagnation in the weakened and dilated vessels of the displaced uterus, as well as other organs contiguous thereto, flows out and seeks remote areas in the head and trunk of the body, which is placed by this maneuver on a lower level. Thus the weight of these organs is diminished, a better

circulation favored in them, and much comfort, if even for a short time, afforded the patient. A special injunction should, for obvious reasons, be given regarding the rectum and bladder, which should be kept as empty as is consistent with health: and all straining and lifting interdicted. Corsets should not be worn, and the under garments must be suspended from the shoulders. Vaginal injections of hot carbolyzed water should be directed once daily at least, and in using them a large amount of water employed; but care will be necessary in taking them lest the pessary be floated from its position by the force or largeness of the stream. The syphon syringe is, except in special cases, to be preferred. Iron tonics should be regularly administered; those containing strychnia being the best—its special action is assumed, being exerted upon the muscular tissue of the uterus as well as that of the ligaments.

The following conclusions seem warranted from the foregoing discussion of this subject:

*First.* That while there exists great difference of views as to the expediency of using pessaries, the practical gynaecologist also is influenced in his opinions by his own individual experience, and will not servilely bow to the authority of those, who perhaps, rejected such aids on insufficient grounds.

*Second.* That the classical pressure symptoms, including weight in the pelvis, sacralgia, bladder and rectal irritation, difficulty and pain on locomotion dragging pains in hips and lower abdomen, etc., combined or uncombined with systematic effects, are relieved by a skilful adjustment of pessaries, and must be continued to be held as an indication for their employment.

*Third.* That in all cases of anaemia, neurasthenia, hysteria, presenting themselves, the cause may be located in some displacement of the pelvic organs, and this point should be determined by immediate examination.

*Fourth.* That due regard must be had to the natural mobility and normal position of the uterus in the placing of pessaries.

*Fifth.* That, contrary to the general view, retroflexion can be redressed and maintained in position by a skilful adjustment of the traction lever pessary.

*Sixth.* That pessaries should be fitted and placed with the patient in Sim's position, this being the most favorable for such procedure.

*Seventh.* That, while the evidence thus far has been discouraging as to the curability of uterine displacements by means of pessaries, we must at least, acknowledge their powerful aid as palliatives, and we are justified in believing that the future statistician will demonstrate their greater efficacy in tables showing permanent results.

•••••  
Belladonna is said to relieve the unpleasant nasopharyngeal symptoms of potassium iodide.



## SOME MODERN REMEDIES IN HEART DISEASE.

BY EARNEST SANSON, M.D.

From an article in the *Lancet* we take the following:—

1. *Digitalis*.—It is a matter of experience with others as well as with myself, that digitalis may not be given in mitral stenosis with the same advantage as in mitral regurgitation. It may often do good if given for periods of a week, with intervals of at least equal length, but it should always be used with caution. In many cases, instead of promoting regularity of the heart's action, it notably increases irregularity. On this point I entirely concur with Dr. Broadbent. The search, therefore, for a more satisfactory therapeutic agent in such cases is very desirable. We will proceed to examine the evidence in the cases treated by—

2. *Convallaria Majalis*.—In cases of mitral stenosis convallaria exercised a pronounced diuretic effect. In all cases the quantity of urine was augmented during its administration. In most of the cases there was no oliguria at the end of the treatment, but the evidence here as well as that in the cases of mitral regurgitation renders it probable that the drug may after the maintenance of a maximum blood-pressure in the renal arterioles, so constrict these as to impede the blood-supply. It will be well, therefore, with convallaria, as with digitalis, to suspend the administration at intervals. It is a fair conclusion that convallaria is an important diuretic in cases of mitral stenosis, comparable in its effects with caffeine in mitral regurgitation, and that its effects in this direction are more pronounced in the obstructive than in the regurgitant lesion. We will now consider the cases of mitral stenosis in reference to the

*Effects of convallaria on the pulse and respiration*.—In one case the pulse-rate progressively fell under ten-grain doses of the convallaria extract, from 112 to 80, 76 to 72, and after suspension of the drug rose to 92, to again fall under digitalis to 70. In another case the pulse-rate which under ten-minim doses of tincture of digitalis had increased from 99 to 110, decreased under convallaria to 102 and 64, rising after the suspension of the drug to 72 and 120. The sphygmographic evidence is more valuable and more conclusive from the mere observation of the rate of the pulse.

The breathing was improved under the drug in nearly all the cases: in one case there was severe dyspnoea, which lasted during a fortnight (in this case bronchitis and emphysema existed in marked degree), but afterwards there was gradual improvement, and the patient left the hospital free from all distressing symptoms. It was evident that in these cases the drug acted very favorably. Only

one case died in hospital: in this pericarditis and severe pulmonary complications were manifested: the patient improving during the time that convallaria was administered, and the temperature was reduced from 101° to normal, but after the omission of the convallaria the temperature rose to 103°: the patient died suddenly after having for a time considerably improved.

So far as I have been able to judge, convallaria compares favorably with caffeine in the treatment of mitral stenosis. In one case a girl, aged seventeen, in whom there existed tricuspid regurgitation, in addition to mitral stenosis and regurgitation, the quantity of urine rose from a maximum of 30 oz. to 54 oz.; but in regard to the pulse and respiration there was no perceptible influence. In another case of stenosis with oedema, the daily urine rose only from 36 oz. to 40 oz., and here also the pulse and respiration were not perceptibly influenced: the patient died. I was not encouraged to repeat the treatment by caffeine in the cases of mitral stenosis whilst I obtained such good results with convallaria: but in cases of this affection manifesting oedema or ascites, where a diuretic effect could not readily be obtained by convallaria, I should administer caffeine in addition.

My general conclusions are that caffeine is an agent of great value in the treatment of cases of mitral regurgitation, especially those in which there is much dropsy; and that convallaria, though manifesting no very favorable influence in cases of mitral regurgitation, except as an occasional substitute for digitalis, is of considerable therapeutic importance in mitral stenosis.

THE HYGIENE OF THE NEWLY BORN.—The following instructions to mothers and nurses, prepared by a commission composed of Moutard Martin, Bergeron, Parrot, Blachez and Dujardin Beaumetz, have been issued by the head of the Department of Public Charities, Paris:—

1. Till the appearance of the first teeth, i.e., between the sixth and seventh months, the only food of the infant should be milk, that of the mother preferably, if she be in good condition, otherwise that of a wet nurse. It is very dangerous to give an infant solid food of any kind during the first months of its life.

2. The child should be offered the breast about once in two hours, and less often in the night.

3. In the event of inability to provide woman's milk, the milk of the cow or goat may be substituted. This milk should be given warm, diluted with one-fourth part water, and slightly sweetened. At the beginning of the fifth month the milk may be taken pure. All other liquids employed to dilute the milk (thin gruel, bread-water, barley-water) are injurious.

4. In feeding the infant, glass nursing bottles



should be employed. These, especially the tubing and the mouth piece, should be thoroughly cleansed every time they are used. Never allow the nurse to resort to those "sugar teats" with which some mothers seek to appease the cries of the infant, and which are sure to produce canker, and disorder the digestion.

5. It is not till the sixth or seventh month that one should begin to allow farinaceous substances with milk, such as bread, baked flower, rice, arrow root, mealy potatoes: these supplementary foods should always form a considerable part of the infant's dietary towards the end of the first year, to accustom the child to weaning. Weaning ought not to be thought of till the first twelve or sixteen teeth have pierced the gums, while the infant is in a good state of health, and during the lull which follows an eruption of teeth.

6. Every morning the "toilet" of the little one should be made before suckling or feeding: this toilet consists: (1) in washing the child's body, and especially the genitals, which ought always to be kept clean: (2) in scrubbing the head, on which it will not do to let scruff or dandruff accumulate; (3) in changing (at least every second day) the child's underclothing; (4) in giving a warm bath in which the infant should be held five or six minutes. The belly band ought to be kept on during the first month.

7. Swaddling clothes, which cause compression of the body, should be interdicted. The more freedom the young child has in its movements, the more robust it becomes, and the better its development. All swathing which encumbers the neck and head should also be discarded.

8. The infant should be protected against the injurious effects of excess of cold and heat, whether out doors or in the house: within doors, the air should be renewed several times a day.

9. It is not safe to carry the babe into the open air before the fifteenth day, unless the temperature is very mild.

10. The child ought not to be allowed to sleep in the same bed with its mother or nurse.

11. The bed of the infant should be composed of oaten straw, soft thatch, or husks: the cradle should have curtains during the first months of infancy, and especially during the cold season, to avoid currents of air, but these curtains should never be completely closed. The babe ought not to be rocked.

12. There should not be undue haste in teaching the infant to walk: it should be allowed to creep on the floor and help itself up: walking carts and baskets should be discountenanced.

13. The least indisposition on the part of the infant (colic, diarrhoea, vomiting, cough) should be at once attended to.

14. As pregnancy has the effect to render the milk less nutritious, in case of pregnancy, every

nursing woman should cease to suckle her infant.

15. It is a good plan to vaccinate infants during the first three months after birth, or during the first few weeks, if an epidemic of small-pox is prevailing.

PRECAUTIONS FOR THE PREVENTION OF PUERPERAL FEVER. — Dr. Macan, in *Braithwaite's Retrospect*: In considering the precautions necessary, the fact is emphasized that we should keep quite separate in our minds the two great classes of infection—auto-infection, where the poison is generated within the woman, and hetero-infection, where the poison is introduced from without.

The latter class being by far the more numerous and dangerous, and almost always due to inoculation with septic matter introduced by the hands of the attendants or by instruments used in operations. Every hand and instrument likely to come in contact with a woman's genitals during pregnancy, labor and the puerperal state should be thoroughly disinfected. The bed linen and all napkins used about the patient should be kept perfectly clean. As soon as the child is born the woman is to be placed slightly on the back to prevent entrance of air into the vagina or uterus, and unnecessary handling of the parts after delivery should be avoided. Before stitching a ruptured perineum or performing any operation, the vagina is injected with carbolic acid solution (1 in 40), and if it is necessary to introduce the hand, the uterus also is washed out. Vaginal and uterine tubes are best made of glass, and kept in carbolic acid solution.

Carbolic solution evaporated in the room day and night renders the air innocuous as possible.

In auto-infection, where the poison is generated within the woman, labor is complicated with a dead fetus, perhaps a fibrous or cancerous tumor of the uterus, a post-partum hemorrhage with badly contracted uterus, followed by formation of clots, or the retention of portions of the placenta or membranes.

The uterus being badly contracted if air enters the vagina, decomposition of the uterine contents result. If the foetid discharge finds a free escape no bad result is likely to follow, but if the drainage is not perfect the discharge becomes more foetid, is absorbed by the system and auto-genetic puerperal fever results. The prophylaxis of auto-infection consists in preventing the air from entering the vagina or uterus, and in quickly removing any foetid accumulation that may have taken place in the uterus, disinfecting its cavity and providing free drainage. This is best done by having the woman lie somewhat on the back after delivery, and the proper application of the binder as preventing a negative pressure in the abdomen. This position is also valuable to prevent accumulations in utero, as the intra-abdominal

pressure is then greater and gravity acts more thoroughly.

A distended bladder or anything preventing uterine contraction should be looked to. If the uterus contracts badly ergot should be given, and if the discharge becomes fetid, hot antiseptic vaginal injections are indicated, which remove the discharge and cause contraction. If discharge remains fetid and the temperature runs high for 24 or 36 hours, intra-uterine injections should be made, and an iodoform pessary introduced.

In all cases where the child is dead and there is any odor, the uterus should be washed out with corrosive sublimate solution, and the iodoform pessary introduced. Iodoform has been used with the greatest success in the Rotunda Hospital. Apart from the antiseptic properties it also lessens the high temperature of puerperal fever.

#### OIL OF SANTAL IN URINARY AFFECTIONS.

Dr. A. P. Gipoulou writes, in the *Journal de Médecine de Paris*, concerning the good results obtained by him from the use of the oil of yellow sandal wood in the treatment of the various affections of the urinary organs. The results of his experiments may be tabulated as follows: 1. In chronic and obstinate gonorrhœa no especially remarkable effects were produced. 2. In acute gonorrhœa accompanied by severe vesical tenesmus, frequent and painful micturition, etc., the acute symptoms were speedily relieved, though the discharge diminished only gradually in quantity. 3. In a case of suppurative nephritis of the left kidney, in which there was frequent micturition, and the urine was loaded with pus, an improvement was noted within twenty-four hours, and at the end of a fortnight the pus had entirely disappeared from the urine. 4. A railway employé was suffering from acute cystitis, accompanied by tenesmus and bloody urine, which had resisted the action of ordinary remedies for over a month; he was relieved permanently in a few days by the use of yellow sandal-wood oil. 5. In a number of cases of vesical catarrh equally rapid and permanent results were obtained. 6. In three cases of simple acute unilateral nephritis speedy relief was afforded by the same remedy. 7. In two cases of nephritic colic excellent results followed the administration of santal oil; the attacks were promptly cut short, and an apparent cure was the result. 8. Finally, Dr. Giloupou relates a case of acute Bright's disease following scarlet fever, in which there was general anasarca and the urine was heavily loaded with albumin. During a treatment for four or five days with diuretics the œdema increased, but within two days after giving santal oil the improvement was marked, and at the end of a week the anasarca had disappeared and no more albumin could be found in the urine.

**UTERINE HEMORRHAGE, NEW METHOD OF TREATMENT OF.**—Dr. Richardson in the *Praktische Artz.*, thus speaks of a new method of treating uterine hemorrhage, which consists in introducing into the external os a crystal of alum of the size of a hazel nut and pressing it back nearly to the internal os. The uterus quickly contracts forming a hard coagulum and arresting the hemorrhage. He also notes that the alum beside its hemostatic power possesses also an antiseptic action, and that he has extracted clots of blood which had remained undecomposed in the cavity of the uterus for four or five days. He recommends removing carefully the placenta and blood clots before introducing the alum. Dr. Richardson has employed this method of treatment for twenty years with uniform success, and regards it as preferable to the means most commonly used, tamponing, injections, uterine friction, application of the electric current, injections of hot or cold water, cold douches to the abdomen, compression of the aorta, and injection of the perchloride of iron. Many of these require special instruments which are not always at hand; others require to be carried out at a great loss of time. Again the injection of styptics is not always free from danger, and the same objections lie against the application of cold. None of these objections apply to the use of the crystals of alum, or perhaps better still the crystals of the double sulphate of aluminum and ammonium. A fragment of crystal may be wrapped in a piece of gauze and introduced into the uterus, leaving an end of the gauze outside of the uterus for convenience in withdrawing the alum when desired. The contraction of the uterus is immediately obtained. This should be allowed to remain for two days without disturbance, at the end of which time an injection of warm water may be thrown into the vagina to wash away the clots of blood. The same treatment may also be employed for hemorrhages arising from other causes. Dr. Richardson having used it with success in two cases of cancer of the uterus with profuse hemorrhage.

**TREATMENT OF PUERPERAL SEPTICEMIA THROUGH THE BLOOD.**—In a thesis, published in the *Medical Press and Circular*, by Dr. C. R. Illingworth, the following extract concerning puerperal septicemia appears:—Here we have a disease in which every effort of nature against the absorption of infective material should be fostered and encouraged. The clots in the maternal sinuses after the separation of the placenta may be regarded as the evidence of this effort, and the preservation of their integrity until they become organized and contracted should be of paramount importance. Hence the advisability of avoiding agents which tend to soften and absorb fibrinous deposits and formations of this nature. Should infection by septic materials from the exterior have taken place, the efforts of

the physician should be directed to strengthen the blood, and thus preserve the fortifications raised by natural means against further infection. This can only be effected by hæmatinic and astringent remedies, such as the perchloride of iron and dilute hydrochloric acid, with the assistance of quinine, chlorate of potash, etc., for the destruction of such germs as have found entrance to the circulation through the lymphatics. To give liqueficient remedies such as ammonia, sodic salicylate, and potassic iodide is simply to break down the natural barrier described, and to further the absorption of septic materials by a diffused and weakened circulation—weakened by reason of its deficient fibrin-forming power and diffused to its own detriment through the midst of the infecting sources, on account of its greater fluidity. Infection of the blood, indeed, is thus doubly ensured, by medicinal liquefaction and septic softening of clots; for wherever there is the development of sulphuretted hydrogen by the decomposition of animal matter, no fibrin can exist.

Besides cleansing the uterus and vagina with injections of Condyl's fluid and carbolic oil, applying antiseptic unguents to any torn portions of the mucous membrane of the passages, and ordering a thorough washing of the external genitals two or three times a day, I prescribe as follows:

Recipe: *Liquoris ferri per-chloridi* ʒj., *quinia disulphatis* ʒj., *glycerini* ʒ ss.—ʒ vj., *aquam ad* ʒ vj. *Misce et solve. Fiat mistura. Signetur: Capiat ægra seminucliam secundis horis.*

**BEEF TEA.**—Dr. J. Milner Fothergill in a brief article in the *British Medical Journal*, September 5, expresses his opinion of beef tea as follows: Fashion prescribes the food of the sickroom to a large extent. Veal-broth had given way to calf's foot jelly when my professional experience first began. Then a patient who had not had calf's foot jelly had been neglected—was the verdict of the public. Now the calf can scamper about in safety: its feet are not in demand. Now it is beef tea which holds the place of honor in the sickroom. The afflicted relatives of a dying man will declare with a distinct consciousness of having discharged their duty in a creditable manner, the quantity of beef, of the very best quality, which has been used to make tea for the sick man—"the very strength of the meat," they will add. Their intentions are excellent, but how about their practice? Are they or are they not talking nonsense? What food value does this vaunted beef tea possess? Answer me that, any of you who can: I will gladly be taught. As a stimulant, as a pleasant vehicle for something else, beef tea is valuable: but its food value is so small that it can scarcely be classed as a food.

I do not desire to speak disrespectfully of beef tea, nor yet of the motives of those who carefully

prepare it, believing it to be a mighty force. I only maintain that to feed—no, that is not the word—to give a patient beef tea as food, is to give him stone when he asks for bread. What that beef tea needs is grape sugar. How can this be added? In all our prepared foods, known generally as "baby foods," starch has been converted into the soluble dextrine or maltose; the one grape sugar, the other only requiring a touch of saliva to complete its conversion. Add some of this material to the beef tea, and then food is supplied to the famishing system. Starch that has long been exposed to heat (either by the baking process or the malting process) is converted more or less completely, into grape sugar. The saliva of a sick person is enfeebled—but on this matter we have only broad impressions, and more precise information is desirable—and so carbohydrates should be provided which do not require insalivation for their solution, being already soluble. Such carbohydrates are now to hand. . . . There are malt extracts containing not only soluble carbohydrates but also some soluble albuminoids and phosphatic salts, ground malt of like composition, also grape sugar itself. The latter is not too sweet to pall upon the palate when added to beef tea or other meat broth.

**PRINCIPLES OF CEREBRAL SURGERY.**—My creed, if I may use the term, is as follows:

I. The complexus of symptoms, called "compression of the brain," is due not so much to displacing pressure exerted on the brain substance as it is to some form or degree of intracranial inflammation.

II. The conversion of a closed (simple) fracture of the cranium into an open (compound) fracture by incision of the scalp is, with the improved methods of treating wounds, attended with very little increased risk to life.

III. The removal of portions of the cranium by the trephine or other cutting instrument is, if properly done, attended with but little more risk to life than amputation of a finger through the metacarpal bone.

IV. In the majority of cranial fractures the inner table is more extensively shattered and splintered than the outer table.

V. Perforation of the cranium is to be adopted as an exploratory measure almost as often as it is demanded for therapeutic reasons.

VI. Drainage is more essential in wounds of the brain than in wounds of other structures.

VII. Many regions of the cerebral hemispheres of man may be incised and excised with comparative impunity.

VIII. Accidental or operative injuries to the cerebral membranes, meningeal arteries or venous

sinuses should be treated as are similar lesions of similar structures in other localities.

IX. The results of the study of cerebral localization are more necessary to the conscientious surgeon than to the neurologist.

From the "Operative Surgery of the Brain," Dr. John B. Roberts.—*Am. Med. Digest.*

**USEFUL FORMULÆ.**—The following formulæ have been used by me for the past three years with uniformly successful results. In the chlorosis of young girls, in all forms of simple anæmia, in amenorrhœa due to anæmia, and in the nervous debility and neuralgias dependent on an anæmic condition, I have never seen a drug; or combination of drugs or chemicals, equal to those given below for rapidly increasing the number of red blood-globules, and bringing the roses to the cheeks of the pale and chlorotic :

R. Strychnia sulphatis . . . . gr. j.  
Sodæ arseniat. . . . . grs. v.  
Hydrarg. bichloridi . . . . grs. viij.  
Potassæ carb. . . . .  
Ferri sulph. aa . . . . . 5 ij.

Fiat pil. No. cxx.

One pill for a dose three or four times a day after food.

Where a patient has an aversion for pills, as many have, particularly in such a quantity and for such a length of time, I prescribe as a substitute the following mixture :

R. Hydrarg. bichloridi . . . . grs. iss.  
Sodæ arseniat. . . . . grs. iij.  
Strychnia sulph. . . . . gr. j.  
Vini ferri amara . . . . . t $\frac{5}{8}$  xvj.

Take two small tablespoonfuls in water after each meal.

Of course, existing errors of digestion must first be corrected, in order that the remedies may be assimilated, after which I can vouch for their efficacy. It will be observed that the pill formula is a modification of the justly celebrated Blaud's pill, but the additional ingredients certainly greatly improve on it. The mixture formula is modified from one in use containing liquor potassii arsenitis, and tincture of nux vomica, but on account of the varying strength and unreliability of these two preparations, the sulphate of strychnia and arseniate of soda were substituted with advantage. The bichloride of mercury in both formulæ, aside from its recognized efficiency in the conditions indicated, is valuable in counteracting the constipation produced by prolonged use of iron.—*M.d. and Surg. Reporter.*

**MEDICAL NOTES.**—For *nervous vomiting*, with constipation, in a healthy girl, Prof. Bartholow directed one of the official pills of aloes and asafetida, ter die.

Prof. Gross advises for the *night sweats* of hectic fever this pill :

R. Zinci oxidi. . . . . gr. ij.  
Extract hyoscamii. . . . . gr. ss.  
Ft. pil. j

Prof. Da Costa treated a case of *cerebral embolism*, causing right hemiplegia, with digitalis; to aid in restoring the collateral circulation, potassium iodide, quinine and laxatives. Result, perfect recovery.

Prof. Bartholow treated a case of *pleurisy* combined with *pneumonia* of low grade, with ammonium iodide gr. v. every eight hours, and ammonium carbonate gr. v. dissolved in spts. of mindererus 5j, every eight hours, so taken that one remedy will be taken every four hours.

Prof. Da Costa directed for a case of *gastric vertigo*, with beginning cirrhosis of the liver, that the phosphate of sodium 5j, be taken every morning; and hydrarg. chlorid. corrosive, gr.  $\frac{1}{10}$ , ter die, to keep up the secretion and to act on the liver. Patient must live on a diet of meat, milk and vegetables; no oleaginous food at all. *Coll. Clin. Record.*

#### Ringworm.

Hydrarg. bichlor., . . . . . gr. ij.  
Naphthol. . . . . gr. x.  
Ung. zinci oxidi benz., . . . . 5 j.  
Ft. ungt. M. —  
Use externally twice a day.

#### Rheumatism.

Chloral hydrat., . . . . . 5 j.  
Acid salicylic. . . . . 5 jss.  
Ung. stramonii, . . . . . 5 j.  
Apply to afflicted joints.

#### Eczema of the Scalp.

Bals. Peruv., . . . . . grs. viii.  
Acid. boracic. pulv., . . . . 5 iss.  
Vaseline, . . . . . 5 i.  
S.—Apply daily. M.

#### ATROPINE SOLUTION IN NOCTURNAL EARACHE.

—Some grown people and many children suffer greatly from constantly recurring earache at night. Children often cry all night from pain in one or both ears; they cannot sleep and will not let others sleep. Mothers and nurses will know how often they are kept from sleeping by a child crying with earache. During the day the child may have no trouble, but as soon as night comes and the child retires; the pain and the crying begin. Without going into particulars as to the character of the pain, I wish to refer here only to the treatment of such cases. In all such cases the very best remedy is a solution of atropine. For children, put one

grain in an ounce of water; for a grown person put 2 to 4 grains in the same quantity of water. Drop 3 to 6 minims into the painful ear and let it remain 10 to 20 minutes, or even let the patient go to sleep with the medicine in the ear. Repeat as may be needed. Sometimes a single application remedies the whole trouble, but at other times it has to be repeated occasionally. Rarely it is necessary to repeat the medicine the same night. I earnestly recommend this treatment in such cases. So far as I now know, it has never disappointed me. The above refers only to repeated attacks of nocturnal earache, and not to acute pain from furuncles in the external meatus or from abscess in the drum. In such cases, the atropine solution would practically have no effect.—*St. Louis Med. and Surg. Jour.*

#### TREATMENT OF NEURALGIA BY NEUBER'S METHOD.

Dr. Schapiro recently read a paper, at the Medical Society of St. Petersburg, upon the results of researches on treatment of neuralgia by Neuber's method of hypodermic injections of a solution of osmic acid. His observations include eight cases of trigeminal neuralgia (three males and five females). The age of the patients varied from thirty-eight to sixty. In every case the disease was of a very severe type and of long standing. The result of the treatment was complete cure in five cases (three females and two males), great alleviation of the pain in two cases, and no success at all in one case (female). The number of injections made in each case was from one to twelve (twenty in one case), five to ten drops being injected every time. The duration of the treatment was from one to sixty days. Dr. Schapiro adopts a modification of Neuber's 1 per cent. aqueous osmic solution on account of the osmic acid soon undergoing decomposition in a watery solution. After a whole series of combinations, he concluded that an addition of glycerine to the watery solution prevents for a long time, osmic acid from undergoing any change. In not one of the cases treated by him was an injection followed by any ill effect. The patients are now under the author's observation (two to six months after the commencement of the treatment).—*Medical and Surgical Reporter.*

#### CONTRA-INDICATIONS TO MERCURY IN SYPHILIS.

At the recent meeting of the British Medical Association. A. Cooper, F.R.C.S., read a paper on syphilis (*New York Medical Record*.) After pointing out the great value of mercury in the treatment of the disease, and the necessity for prolonged courses of the drug, he draws attention to the contra-indications, which many physicians are apt to overlook or to neglect. Mercury should not be given to phthisical subjects, unless the chest affection is slight and the patients health is good in other respects. When albuminuria exists mercury

must, of course, be withheld, unless there is reason to believe that the renal affection is due to syphilis. When syphilis exists in scrofulous subjects, if the symptoms of scrofula are not very severe, mercury may be given with care in small doses. Mercury is contra-indicated in profound anemia, when non-specific. The least symptom of sloughing or phagedena should prevent any thought of administering mercury. If any of these complications set in during a course of the medicine, it should be at once discontinued. Alcohol and tobacco should be avoided or used sparingly during a course of mercury. Exercise and fresh air tend to prevent salivation, and the skin should be kept perfectly clean. Confinement to the house is desirable when any eruption appears.

**THE THERMO-CAUTERY IN ENLARGEMENT OF THE THYROID BODY.**—The method of Dr. Weiss consists in touching the skin over the tumor with a small Paquelin's cautery, held like a pen. Touches with this instrument are made in horizontal rows, the rows being about one centimetre apart, and the touches in each row being close together. If the cautery be at a white heat, the procedure causes very little pain. Anæsthesia, general or local, is quite superfluous, and so is all after-treatment, but a little cotton-wool may be laid upon the site to prevent friction by the clothes. A thin dry scab falls from each spot after about six days. After seven or eight days the procedure may be repeated, and so on for six, eight or a dozen times, according to the extent of the original enlargement. It is most valuable in the purely hypertrophic variety, but in the cystic also is of great advantage if the cysts be punctured with a Pravaz's syringe. In obstinate cases, the above method is rendered somewhat more severe by applying vaseline directly after the use of the cautery. The effect is to cause the premature separation of the small scabs, which is followed by a slight suppuration for a few days. The explanation of the good effects of Paquelin's cautery, so applied, is presumably this: Weiss believes that the irritation brought to bear on the nerve-endings in the skin causes constriction, more or less persistent, of the arterial muscular coats, which induces defective nutrition of the hypertrophic gland-substance and its gradual disappearance.—*Med. World.*

**BROMIDE OF ARSENIC IN ACNE.**—Dr. Henry G. Piffard, writing in *Journal of Cutaneous and Venereal Diseases*, says:

Conceiving, from purely theoretical considerations, that it might be useful in certain cases, I first tried it in the spring of 1878, in a case of pustular acne vulgaris of moderate severity, and gave it in doses of one milligramme (gr.  $\frac{1}{60}$ ) three times a day. Within a week the patient, a young lady, returned, complaining that her face was

much worse. On examination, I found on each side of the face a crop of miliary pustules in addition to the acne. The arsenic was discontinued, and a placebo was prescribed. This was followed by improvement for a week, when arsenic was resumed in much smaller doses, and in three or four weeks the case was substantially well. In a second case I had a similar experience, and in a third case I prescribed an alcoholic solution, containing one grain to the ounce, and directed that two drops should be taken night and morning. This patient I did not again see for nearly six months, when she informed me that the medicine had, in a few weeks, accomplished all that she desired. Since then I have used bromide of arsenic with much satisfaction in pustular acne, but have not used it in other varieties of this affection, nor in other cutaneous diseases.

**TREATMENT OF GONORRHOEA WITH ANTISEPTIC INJECTIONS.**—Dr. A. Bourgeois has recently published an important article on the treatment of gonorrhœa with antiseptic injections. Since the microbiologists have affirmed the existence of a gonococcal cause of gonorrhœa, the whole problem in the author's opinion, consists in finding an antiparasitic topic, sufficiently energetic, but innocuous to the mucous membrane. It is thus necessary to lay aside all very irritating substances: the three parasitocides which seem to him to unite all required conditions are permanganate of potash, bichloride of mercury, and sulphate of quinine. He employs the permanganate in solution (1 to 2,000), the bichloride (1 to 20,000), the sulphate of quinine (1 to 100). Four injections are to be made in twenty-four hours, one in the morning, one at noon, one at seven o'clock in the evening, and the other during the night; this last is indispensable, according to Dr. Bourgeois since, if the microbes be left to response during the entire night, they will have time to multiply. The injection should be warm, as it thus penetrates more easily into the urethra: it should not occasion pain; if so, it should be diluted until it can be well tolerated. A glass syringe, well graduated, capacity of eight grams, should be used. The injection should be made to entirely fill the urethra, but not to forcibly distend it and produce pain and perhaps injury to the mucous membrane. It is much better to use colored liquids, since one can thus better judge of the quantity introduced into the urethra. After having diluted the first injections, the patient will gradually get accustomed to the full strength recommended above. The patient should be directed to urinate one-quarter of an hour before, and as long as possible after the injection.

In order to insure the penetration of the medicated liquid to the desired depth, Dr. Bourgeois has devised another procedure, which consists in

introducing within the urethra, to the depth of about eight centimetres, a cylindrical gum sound of medium calibre, open at its two extremities, without lateral eyes. This is first smeared with iodoform ointment, (1 to 20) and a glass syringe, holding eight grammes of the injection, is fitted to its free extremity, and the liquid is gently forced into the urethra, the instrument being at the same time gradually withdrawn, so that the liquid replaces the sound in the canal, where it is retained from ten to fifteen minutes. Two or three such operations should be made in the course of twenty-four hours. In addition, the author gives to his patients, during the entire course of the disease, one or two grams per day of bromide of potassium, with a view of preventing all generic excitement. He also treats the constitutional condition of his patients with appropriate medication.—*Jour. of Cut and Ven. Diseases.*

**WHEN TO TIE THE UMBILICAL CORD.**—Dr. Engel, in the *Centbl. f. Gynak.*, strongly recommends that the cord should not be tied till all pulsation in it has ceased, and in the course of his paper mentions the following facts as evidence of the importance to the child of the small quantity of blood saved to it:—"He contrasts the mortality of all the premature children born in the Klausenburg Hospital during the last eight years, during the first four of which it was the custom to ligature the cord immediately on the birth of the child, while during the latter four the plan of treatment he advises was practiced. During the first period there were 90 premature undersized and underweighted children born, of whom 17, or 18.88 per cent., died within ten days of birth, while during the latter period there were 74 such births, of whom 10, or 13.51 per cent., died within the same time. In cases where the mother became feverish, a wet nurse was had recourse to. "This striking difference of mortality can only—in the absence of any other visible cause—be attributed to late ligature of the cord."

**IN ACCORDANCE WITH THE LETTER AND SPIRIT OF THE CODE OF ETHICS.**—At a recent banquet Sir Spencer Wells told a story from his personal experience as a young man, which has in it a lesson for the older men of to-day. He had been called in the absence of Dr. Braithwaite, the family physician, to see a girl whom he found lying, insensible, on the bed. Not knowing what to do he gave some brandy-and-water. Dr. Braithwaite then arrived, and after examining the case ordered two teaspoonfuls more of the mixture, but as soon as he was alone with Wells, said: "It was very wrong to give her brandy-and-water. It is the first stage of some eruptive fever. But a teaspoonful won't make any difference, and it will show that I did not differ from you. If I had."



he added, with a kind smile, "perhaps they would not believe either of us." There was something in this way of treating a junior—so much good feeling, mixed with so much knowledge of human nature—which so impressed the future Sir Spencer as to influence him in his consultations with his juniors. —*Medical Age.*

**HENOCH ON THE TREATMENT OF PERTUSSIS.**—The following, originally a clinical lecture on the subject, embodies the principal views of the Berlin authority.

Pertussis is an affection the treatment of which confers but little credit on those who have embraced the healing art. The enormous number of remedies alone, recommended since the oldest times against this affection is proof enough of its incurability. We know no drug capable of aborting the affection or shortening its convulsive stage; while on the other hand, in its third phase, the so-called stadium decrementi, when the natural healing process has set in, every remedy is apparently successful. The numerous drugs which, following the recommendations of other physicians, have been tried, have been nearly all discarded. At present, Henoch relies solely on one remedy, viz., morphine, which is even superior to the vaunted belladonna medication, and is at least able to lessen the gravity and frequency of the paroxysms, especially the nocturnal ones, without, however, influencing the general course of the disease. Henoch usually prescribes the following:

R Morph. acet. s. mur, . . . gr.  $\frac{1}{4}$ – $\frac{1}{2}$   
 Aq. dest., . . . . . fʒi;  
 Syr. alth., . . . . . fʒss. M

S—A teaspoonful two to four times daily.

If excessive somnolence should set in, the drug is at once to be discontinued. In one instance a child, being treated by morphine, slept for eighteen consecutive hours without being interrupted by the paroxysmal coughs, which of course returned after the passing off of the narcosis. In another case, that of a six-months-old child, there was an actual intoxication proceeding with collapse, contraction of the pupils, and sopor, which, however, readily yielded to cold affusions and analeptic measures. It is therefore necessary to instruct the nurses and mothers in every instance of the nature of the prescribed medicine. Using the proper precautions, Henoch states that he has never experienced any accident with the morphine mixture, even if half a teaspoonful of it were given daily for several weeks. He consequently feels justified in preferring this drug to all other narcotics, especially to the dangerous atropine. Still, he regards the morphine only indicated in the graver cases, marked by at least twenty paroxysms within twenty-four hours. In milder

cases, inhalations of carbolic acid recommend themselves, which on the ground of the alleged—but hitherto not yet demonstrated—parasitic nature of the affection, appear even theoretically indicated, and have recently acquired a certain reputation with many practitioners of renown, such as Thorner and Burchard. In Henoch's experience this medication has not furnished any constant results, its effects being sometimes remarkably favorable, sometimes doubtful, or again wholly negative. Injurious effects at least have never been witnessed from these inhalations. Their application can be executed in various ways. Henoch uses a one-half per cent. solution of carbolic acid by means of an atomizer, or if this procedure meets with difficulties, orders the air of the sick-room to be impregnated with the same evaporating solution, or a sponge saturated with it to be hung up at the child's bed, over its head, and have the sponge placed several times daily before the nose of the child for a period of several minutes. Other inhalations, such as those of chloroform, benzine, salicylate of sodium, oil of turpentine, tannic acid, and quinine, have all received fair trials, but have not given the expected satisfaction. The same holds true of the internal use of bromide of potassium, of hydrate of chloral, and of quinine. Following the instruction of Dr Sauerhering, of Stettin (*vide Therapeutic Gazette*), the systematic exhibition of quinine in gradually increasing and then decreasing doses has also been tried, and again convinced Henoch that the morphine medication and the carbolic acid inhalations were the best treatment of whooping-cough.

Therefore the idea of aborting or lessening the duration of the affection will have to be abandoned, and the parents must be instructed that a mitigation of the attacks is all that can be expected from the treatment. Fresh air is a decided adjuvant to the prescriptions, though damp and rough weather and the existence of a pronounced bronchial catarrh contraindicate an out door sojourn. If the child be attacked during the summer months, one will often be asked whether a trip to the sea-shore be advisable or not. Henoch says that he has often complied with the wishes of parents in this respect, but never saw any benefit from such a change of locality, and the only, though lamentable, result of the journey was often the infection of previously healthy children who came in contact with the sick child at the sea-shore or watering-place. Only exceptionally, as in his own child, he observed a characteristic pertussis disappear in fourteen days after the child had been sent to the Reichenhall Springs. Still, he believes with Trousseau in the existence of so-called abortive cases of whooping-cough, and that the affection in the case alluded to belonged to this category. Trousseau, by the way, has reported a case of genuine pertussis which aborted after a three days' duration.



**THE TREATMENT OF STRANGULATED HERNIA BY IRRIGATIONS OF ETHER.**—Dr Bartosz writes, for the last two years he has been applying with brilliant success irrigations of ether for the reduction of all cases of strangulated hernia which have come under his care. The irrigation is made after the method of Finkelstein (*Bull. Gén. de Thé.*, December 15, 1885), which consists in pouring on the tumor every half-hour a tablespoonful of ether, and allowing it slowly to evaporate. The hernia under such treatment disappears spontaneously, or may be readily reduced in obstinate cases, by gentle taxis. In the seventeen cases in which the author states that this method served to reduce the hernia, strangulation had persisted in some only a few hours, while in others it is stated to have lasted already for several days, before the cases were subjected to treatment. The author further refers to a case of intestinal occlusion in a woman 60 years of age, in whom absolute constipation had existed for nine days, incessant fecal vomiting and tympanites, thready pulse, etc., in whom, after a fruitless trial of all the known remedies, irrigation of ether on the entire abdominal surface in one and one-half hours caused a large evacuation of the bowels and the cure of the patient. This method of irrigation so employed by Bartosz may be replaced by driving the current of air from a bellows over the ether. Whatever, however, may be the means adopted, the ether acts by the refrigeration which its evaporation produces, and is therefore analogous to the application of ice, and is consequently simply an improvement of the method whose value has long been recognized. We should think however, that where the strangulation lasted for several days, as is stated by the author to have been the case in one of his instances of cure, even if the reduction of the strangulation should take place, there must be the greatest danger incurred in the return to the abdominal cavity of a knuckle of intestine which cannot but be gangrenous.

**WINTER-TIRE.**—It is a curious fact that the farther north we travel the hotter habitually are the interiors of the houses. At first thought it would seem natural that the temperature in which the person lives in the house should approach more closely that of the external air, but a little consideration shows the reasonableness of the habitual action of northern nations. The man who is exposed all day to a low temperature must produce an enormous amount of caloric in order to meet the demand and keep his body warm. At eventide he naturally seeks rest, not only for wearied mind and muscle, but also for the heat-producing function. It is not always remembered that energy is expended in maintaining bodily temperature, and that when an excessive amount of such energy is required, excessive exhaustion follows. The habitual excessive draught of the winter-time upon heat produc-

tion is probably one of the reasons that in the early spring every one feels so relaxed and depressed. Of course, the general relaxation and lack of energy which has received the popular name of spring-fever, and which is supposed by many to be moral rather than physical, is due in part to the fact that the winter is, at least to many brain-workers and denizens of cities, the period of excessive toil. Nevertheless, it should be called winter-tire rather than spring-fever.

This relaxation of the system shows itself not only by the production of laziness, but also in manifestations of distinct disease. A good deal has been written in the course of the last decade concerning the fact that in children chorea is so much more frequent in the spring than at other times, but our own experience is that in this respect chorea does not stand alone among nervous diseases. Neurasthenic conditions, hysteria, and all the minor or functional nervous ills which are connected with lowered nerve tone have come under our notice as a regular spring crop, and we think most neurologists will find that the months of April and May are those of greatest professional activity.

**A RESULT OF EXTENSION IN THE TREATMENT OF FRACTURE OF THE THIGH.**—Dr. Fischer reports a case of fracture of the thigh in a child six years of age, which was treated by extension with weight and pulley. A cure was obtained in four weeks, but it was then found that the ligaments of the knee had been so stretched that the ends of the tibia and femur slid over each other with an audible sound, and hyper-extension occurred when an attempt was made to stand. The trouble was relieved by retention for a month in a silicate of soda splint. The cord passed over two pulleys and a weight of eleven pounds was used. Dr. Schmidt, in referring to this case, reports a similar instance of over-stretching of the knee in an old woman, with fracture of the femur just above the condyles. In both cases the trouble was due to the continuous traction maintained by plasters attached only to the leg and pulling through the knee-joint.—*Centralblatt für Chirurgie.*

**TREATMENT OF ACUTE CORYZA.**—Dr. S. S. Cohen, in a recent communication to the *Philadelphia Med. Times*, recommends, as a specific against acute coryza the 1-120th of a grain of atropia, to be repeated every four hours until there is dryness of the throat. He says that this remedy will cure nine out of ten cases of coryza if taken at the incipency of the disease. Afterwards to relieve the unpleasant symptoms of dryness he has given one-seventh of a grain of pilocarpine with good results. When cases are seen too late to use atropine with advantage, he has obtained good results from ammonium salicylate in doses of ten to fifteen grains

repeated every two hours until tinnitus aurium is produced. If the patient does not object to the expense, cocaine can be used to allay the local symptoms until the medicine has had time to act.—*Western Med. Reporter.*

**THE HYGIENE OF PREGNANCY.**—Let the patient eat but little in the latter months, though she may eat a little frequently during the day. A large meal causes much inconvenience, due to the already enlarged abdomen. A bandage properly applied around the abdomen is useful and comfortable. She should sleep eight hours; and take an occasional bath in tepid water. If leucorrhœa be present, let her use an injection of salt water, and bathe the external genitalia with tepid water. For the breasts, use oily matters, and no alcohol. In the morning the nipples may be painted with equal parts of tincture of arnica and water, but in the evening should be covered with cocoa-butter. High-heeled shoes should be dispensed with during pregnancy.—*Coll. and Clin. Record.*

**DIET IN ALBUMINURIA.**—After passing in review the principal theories which have been given regarding the pathogenesis of albuminuria, Nollet offers the following conclusions:

1. Milk diet has as yet given the best results in the treatment of albuminuria.

2. This method is not applicable to all forms, and if too prolonged may produce serious inconveniences for the patient.

3. The albuminuric should avoid large meals, eating frequently, but little at a time.

4. Individual susceptibility must determine the sorts of animal food least injurious to the patient.

5. Fish appears to favor the passage of albumen into the urine.—*Gaz. Méd. de Paris*, March 6, '86.

**THE DIET IN DIABETES.**—*Articles permitted:* Almonds, plain, in rusks and in biscuits, bread toasted or stale maccaroni, bacon, butter, cheese, eggs, fat and oils, beef-tea and soups, beef, mutton, fish, game, and poultry, cabbage, lettuce, pickles, and spinach, custards without sugar, cream, jellies unsweetened, nuts: coffee, cocoa, sherry. *Articles forbidden:* Peas, beans, lentils, potatoes, sweet potatoes, celery, carrots, beets, radishes, mustard, oysters, arrow-root, buckwheat, sago, tapioca, and puddings generally, apples, bananas, and fruits generally, including raisins; milk, sugar, chocolate, ale, sweet wines.—*Journal of Reconstructives.*

**JEQUIRITY IN GRANULAR LIDS.**—Dr. Peonhoff, having used jequirity in twenty cases of granular lids, varying among one another in character, has come to the conclusion that it is especially useful in a cicatricial condition of the granulations when this is complicated with corneal disease. In these cases, he says, jequirity cures much better and

more rapidly than the usual remedies, nitrate of silver, sulphate of copper, etc. It is also valuable in mild cases of follicular trachoma with ingrowing eyelashes. The best method in all cases is to use a one or two-per-cent. of the powdered seeds of jequirity daily.—*London Lancet.*

**THE TREATMENT OF BURNS.**—Altschul ("*Monatsheft f. prakt. Dermat.*") reviews the treatment of burns, and gives the results of his own experience. Iodoform he regards as the application *par excellence* for burns of the second and third degrees; he prefers an iodoform-gelatin of the strength of ten per cent., or, better still, an iodoform paste, of which the following is the formula:

White bole, . . . . .  $\frac{1}{2}$  drachm;  
Olive-oil, . . . . . 1 ounce;  
Solution of subacetate of lead 6 drachms;  
Iodoform, . . . from 2 to 4 drachms.

**PELVIC NEURALGIA.**—In congestions or plethora of the pelvic organs, with accompanying neuralgia, in women, the following formula frequently gives decided relief:

R Pot. bromid, . . . . .  
Amm. bromid, aa . . . . .  $\bar{3}$  iss.  
Tinct. guaiac., . . . . .  
Tinct. colchici, rad., aa . . . . .  $\bar{3}$  ss.  
Syr. simp., . . . . .  $\bar{3}$  iij.  
M. Sig.—Teaspoonful three times a day.

**SCABES.**—The following is Hebra's modification of Wilkinson's ointment:

R Flor. sulphur., . . . . .  
Ol. fagi., aa . . . . .  $\bar{3}$  iss.  
Creta alb., . . . . .  $\bar{3}$  i.  
Saponis viride, . . . . .  
Ungt. simpl., aa. . . . .  $\bar{3}$  iij.

M. Rub thoroughly into the skin after a hot bath.

**RHUS POISON.**—The following is recommended in rhus toxicodendron poisoning.

R. Corrosive sublimate, . . . . .  $\bar{3}$  ij.  
Amm. mur. . . . .  $\bar{3}$  iv.  
Potass. nit., . . . . .  $\bar{3}$  j.  
Aque font., . . . . .  $\bar{3}$  xvj.

M.—Sig. Dissolve, and wash the parts in this solution twice a day. It cures the itch with equal certainty.—*Med. Brief.*

**INDUBITABLE CONGENITAL TUBERCULOSIS.**—An eight months' foetus was taken from a cow, the subject of advanced tuberculosis, by Dr. Johne. The placenta and uterus were free from tuberculous lesions, but in the lower lobe of the right lung a nodule the size of a pea was detected containing four caseous centres. The bronchial glands were congested and also tuberculous. The liver con-

tained numerous gray granulations. Microscopically, the tubercular structure was confirmed: masses of epithelioid cells with giant corpuscles containing tubercular bacilli were discovered.—*Lancet*.

**CONVULSIONS IN AN INFANT CURED BY MORPHINE.**—Dr. H. Plummer, of Harrodsburgh, Ky., reports in the *Medical Record* for March 27, 1886, the case of an infant, 22 months old, who was seized after a short period of malaise with convulsions. She was seen after the second convulsion, and did not then appear to be very ill, but was fretful. The temperature was 102° and there was some little cough, but there was no signs of pneumonic trouble. Bromide of potassium in 5-grain doses was given every hour, but the convulsions increased in severity and frequency. The bowels had been moved by calomel and castor oil. In the afternoon of the second day the child was in the following condition: The tongue was protruded between the teeth, swollen, and constantly in motion; the fore-arms were flexed and rigid, the thumbs being firmly drawn into the palms, and the lower extremities were likewise rigid. The child was now unable to swallow, and the pupils were widely dilated. The convulsive attacks recurred at such short intervals that they seemed to be continuous. Other remedies having proved ineffectual, Dr. Plummer determined to employ morphine, and accordingly gave  $\frac{1}{2}$  grain hypodermically. In a few minutes the little patient fell into a sleep, in which she remained, awaking only to drink, for twenty hours. The pupils became of nearly the normal size, and the muscular system became relaxed. From this time she continued to improve, although she seemed nervous and fretful, for a time, and the convulsions did not return.

**CHLORIDE OF CALCIUM AS A GLANDULAR DEOBSTRUENT.**—Dr. Arthur Davis thinks that this old and formerly much used drug is not sufficiently resorted to in cases of enlargement of the lymphatic glands, and he relates two cases wherein the results were very satisfactory. He utters the caution that the drug must be given in solution in doses of from three to ten grains thrice daily, according to age, and he concludes that in the application of this drug, therefore, three points should be borne in mind:

1. The necessity of a cautious but gradual increase in the strength of the dose taken.
2. The steady persistence in its use for a lengthened period.
3. Its uselessness in cases where suppuration has already commenced.—*Med. and Surg. Reporter*.

**THE TREATMENT OF FEVER BY ELECTRICITY.**—Prof. E. De Renzi having by chance observed a case of quartan fever cured by the application of

electricity, instituted a series of experiments in this direction, and has formulated as a result of these observations, the following conclusions:

1. Fevers of malarial origin resist the action of the electrical current much more than do those symptomatic of bronchitis, pulmonary phthisis, etc.
2. During the application of electricity the temperature remains elevated, or even rises to a fraction of a degree: but soon after, at the most within an hour or two, a fall of several degrees occurs.
3. The best effect is obtained by holding a moist electrode in the hand while a metallic brush attached to the other pole is swept over the surface of the body.
4. Arterial pressure is increased during the application, the skin becomes reddened and often moistened with perspiration, and the pulse is increased in force. It is probable, therefore, that the antipyretic effect of electricity is due to the increased activity of the cutaneous capillary circulation, whereby caloric is more rapidly lost.—*Gazetta Medica Italiana*.

**MALIGNANT TUMORS OF THE NOSE.**—*Revue. Mens. de Laryngog.* Schmiegelow, of Copenhagen, has observed and described three forms—sarcoma, carcinoma, and lupoid polypi. The latter resemble tubercular vegetations of the larynx and trachea: their surface is white, granular non-translucent, hard, but less so than the fibromata. In two cases they were attached to the septum, middle and inferior turbinates. The structure is like that of a tubercle. Carcinoma is rare, sarcoma somewhat more frequent: the former is slow of progress, occupying months and even years, whilst the evolution of a sarcoma usually takes weeks: carcinoma is more superficial, ulcerates more quickly, is less hard than sarcoma. Epistaxis is by no means an habitual sign of either, and infiltration of the lymphatics is not the rule, though visceral metastases have been observed. In Schmiegelow's case of carcinoma its origin, usually from the ethmoid, was from the cartilaginous septum and its histological type cylindrical. Growths limited to the nasal cavities proper, excepting the ordinary soft polyp, are so rare that every case should be minutely described and published.—*St. Louis Med. and Surg. Journal*.

**SYPHILIS OF THE BRAIN.**—In this dangerous manifestation of syphilis, from whatever pathological condition arising, Dr. Gerhardt places his reliance upon mercurial ointment and iodide of potassium for treatment. If the treatment is begun early enough, many of the cases are curable: but if treatment is delayed, there is no hope. Treatment must be begun early, and must be energetic and long continued. He uses daily

unctions of ungt. hydrarg. in doses of three to seven grams, and administers at the same time from two to five grams of iodide of potassium. The more the patient moves about in the open air, the greater, proportionally, must be the amount of ointment rubbed in.—*Berliner Klin. Wochens.*—*Archives of Pediatrics.*

**ACNE AND ITS TREATMENT.** Young people are subject to acne, which many think is caused by some change in the blood. The disease is seen in many instances about the age of puberty. It is marked by a popular eruption on the face, sometimes interferes with the digestion, and has a low fever. The indications are to give a simple cathartic. *Medical Summary.*

**A MUSTARD SPONGE.**—Dr. B. W. Richardson recommends the use of a sponge for mustard poultices. He says: "A sponge makes the best of mustard carriers. The nurse mixes the mustard in a basin with water until the mass is soft and of even consistency. Then she takes the soft mass all up with a clean sponge, lays the sponge in the centre of a soft white handkerchief, ties up the corners of the handkerchief neatly, to form a hold, and applies the smooth convex surface to the skin. This mustard sponge, warmed again by the fire and slightly moistened, can be applied three or four times, is good for several hours, and saves the trouble of making a new poultice for re-application, often a matter of importance during the weariness of night watching. The sponge can afterwards easily be washed clean in warm water."

**MENTHOL IN THE TREATMENT OF URTICARIA AND PRURITUS.**—Among the myriad of remedies for these troublesome affections we have used this remedy for urticaria in three cases. Not only is the itching relieved for the time, but a cure seems to be effected. In pruritus ani, and in eczema, moistening the parts with menthol solution causes an immediate cessation of the pain. The solution should contain from two to ten grains of menthol to the ounce of water.—*Exchange.*

**FOR WORMS.**—Prepare six powders, each containing from three to five grains of santonin, according to age, and a fourth of a grain of calomel. The first two powders to be taken at twelve hours interval, the remainder at twenty-four hours interval. Followed by a dose of castor oil, "Infallible."—*Brit. Med. Jour.*

**A LIBERAL OFFER.** The editor of a newspaper in this State thus appeals to his delinquent subscribers: "To all those who are in arrears one year or more, who will come forward and pay up arrearages and for a year in advance, we will give

a first-rate obituary notice gratis in case it kills them."—*The Sunny South.*

**TREATMENT OF LEUCORRHEEA AND FETID VAGINAL DISCHARGES.**—Dr. Cheron orders the following injections morning and evening:—Chlorate of Potash, ʒ iij.; laudanum, ʒij.; aque rhenicæ, ʒx. Two or three tablespoonfuls for a quart of warm water.—*Medical Press and Circular.*

**ANOTHER USE FOR COFFEE.**—Chewing coffee is said to effectually remove the disagreeable taste following galvanism to the head and neck.—*Peoria Med. Monthly.*

"Yes! You doeters are great fellows," said the man on the cracker-box to a young M. D., near by. "You put a long name onto everything, and then people forget it. Oh, yes! I know. You call water aqua and pumpiosis, and you call tar, fix liquidator, just as if people did not no what a fix was. You say if a man has lung fever, that he has the ammonia; and if he gets a cold, you say he has the brown skitters. But you don't foöl a man that's been brought up in Philadelphia. You call wax, ce-rat-um, and call a mixture of baking soda and acid, sigh-lets powders, and so you go on thinking to cheat honest folk. And now you expect people to believe in you, but we won't until you come right out and call things by their proper names—" Just then some one rushed in and said there was a dog fight down street and the groceryman was left alone.

A woman once consulted Abernethy for an ulcer on her arm, and when asked, "What ails you?" exhibited the sore without speaking. "Poultice it, and take five grains of blue mass every night; come back in a week!" The woman offered the usual fee, which the surgeon refused. At the end of the week the patient appeared, and the same pantomime occurred. After a few more visits, the doctor looked at the arm and pronounced it well. The patient again offered a fee. "No," said Abernethy, "I will take nothing. You are the most sensible woman I ever met. *You don't talk!* A few months afterwards he discovered that the woman was *dumb*.

Prof. Da Costa speaks highly of a double salt of sodium and iron, the pyrophosphate, in the treatment of anæmia. As it is unirritating, it is the best salt for hypodermic use. It is freely soluble, and can be given in large doses as it does not irritate the stomach, nor does it produce constipation.

Professor Parvin recommends as a remedy for the salivation of pregnancy, the smoking of the fourth of a cigar several times a day.

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News.**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the Editor Canada Lancet, Toronto.*

AGENTS.—DAWSON BROS., Montreal; J. & A. McMILLAN, St. John N.B.; GEO. STREET & Co., 30 Cornhill, London, Eng.; M. H. MARLER, 23 Rue Richer, Paris.

TORONTO, JUNE, 1886.

*The LANCET has the largest circulation of any  
Medical Journal in Canada.*

## RECTAL MEDICATION AND ALIMENTATION.

That the rectum possesses no mean powers of absorption has long since been established; yet we fear its great importance is not generally recognized, and that insufficient attention has been given to the many advantages of rectal medication and alimentation. Many important diseases are in proximate relation to this cavity, and consequently are more readily affected by remedies, thus administered, than by any other mode. Liebig states that a 20% solution of salt injected into the rectum will disappear completely in one hour, so completely that an evacuation at the end of that time, will be found to contain no more than the usual quantity of salt. The fluid extract of rhubarb has been detected in the urine one hour after injection into the rectum, and abundant proof has been obtained, that most if not all liquid or soluble remedies are absorbed by the rectum with great facility. Hence we may confidently administer medicines per rectum whenever indicated, especially for pelvic ailments. Comparatively few resort to this method, even for diseases of this locality, because of their want of confidence in the absorbent powers of the rectum: yet the few who have given it a fair trial, seldom return to medication by the stomach for diseases of the bladder, prostate, womb, ovaries, testicles, lower bowel, etc., etc. Medication by rectal suppository or capsule, is simple, direct and cleanly, and when indicated remedies are properly selected and

prepared, is very efficacious. The advantages of this mode are obvious; the stomach is left free for food, the disgust produced by nauseous medicines, their probable rejection by the stomach, the troubles of administering to children and delirious patients, and many other practical difficulties are all obviated. Rectal alimentation also deserves more practical attention than it has hitherto received. Although the practice has obtained from the earliest period, and is probably as old as the science of medicine, yet we have not availed ourselves of its great utility, to the extent which its importance merits. Herodotus states the Egyptians used clysters at certain times for their health, and the ancient Greeks injected wine, whey, milk, ptisan, broth of spelt, etc., for this purpose. The Romans availed themselves of this method of administering nourishment, as a sustaining treatment, as well as most other civilized nations of which we have any record. The practice has continued to ebb and flow, with the fashion of the period, down to the present day. Many prominent physicians of the last and present century have strongly advocated its utility, and urged its more frequent adoption by the profession. The use of pancreatized enemata has been known for over two hundred years. It is mentioned in a Latin treatise published in 1671. It behoves us then not to permit this important means of sustaining life, under adverse circumstances, to languish or become obsolete at the present day. That its necessity and utility are as important to day as in the past, will not be disputed, nor has it been superseded by any other method of administering nourishment, when the stomach, from any cause, fails to perform its duties. Now that science has furnished us with the means of supplying food partially if not wholly digested, and prepared for absorption, rectal alimentation should attain better results than in former days, and should be more frequently resorted to, if we would avail ourselves of every means in the interest of our patient. Pancreatized and peptonized aliment, in a liquid or semi-liquid form, is readily absorbed by the rectum, and will sustain life for an indefinite period. Its utility in the large majority of diseases is so obvious, that enumeration would be superfluous. We have barely hinted at a few of the points of this very important subject, but all will easily conceive its necessity in every-day practice, and we trust will not fail to recognize its great importance.

not only to the patient, but to the physician, if he would be successful in combating disease, and postponing the dire event of our mortality, to the latest period allotted to man.

### FEVER.

The theory of fever, or increased body temperature that has been so long familiar to us, seems to be insufficient. We have been accustomed to say quite glibly, that the increased heat is due to increased oxidation of the tissues—to a degradation of their histological elements, under the influence of some cause, hitherto rather shadowy. Some of the most advanced, and most scientific minds in the medical profession, have become skeptical as to the fact, that this degradation of tissue is the prime and only factor in the process. It may, therefore, almost be put as a corollary to the above proposition, that new light will be thrown upon this difficult, but interesting and important subject, just as the old theories about heat and light were supplanted by the present ones, as soon as science acquired facts which were not consonant with the old theories. The thought has been suggested that a portion of the heat manifested in fever is produced by a checking or lessening of the processes of tissue-building. We know that during fever the processes of repair, so to speak, are in abeyance. The various tissues waste, and no sufficient renewal goes on. Now by what means, in health, are the tissues built? Is not a certain amount of force necessary for the performance of what we call the vital functions? The weaving of cells, the secretion of juices, the elaboration of tissues: surely these processes require a certain amount of motion, or chemical action, or what ever form of energy it may be, and this we may now put down as heat, or as some force in the manifestation of which heat is used up or rendered potential. If this be true, we have advanced considerably in our capability of understanding that fever is due not only to increased oxidation, from the rapid disintegration of the tissues, but also to the non-disappearance of a certain amount of force necessary for the elaboration of the various aliments, their assimilation and the subsequent tissue-formation. It has been clearly shown that during febrile states more heat is given off; that is, the increased body heat is not due to its reten-

tion in the body. Unfortunately for the theory, all observations so far made, upon animals, appear to show that in all the processes of the body heat is evolved or rendered sensible, and not latent. But recent observations, very carefully conducted by Mr. Ord, show that in certain growing fruits, *the temperature is lowest* where the greatest amount of tissue-building is going on. The cucumber was selected for these observations, and Mr. Ord found that the thermometer registered a difference of as much as  $1.1^{\circ}$  in different points of the same cucumber, being lowest where growth is most rapid, *i. e.*, at the tip, and at the stalk end. He also found a difference of  $2.9^{\circ}$  between a ripe and a growing cucumber placed under similar outside conditions; that a ripe cucumber, that is, one in which disintegration of tissue was going on, showed a temperature  $0.6^{\circ}$  higher than a bottle of water suspended beside it, while a young growing one was  $2.3^{\circ}$  lower than the water. These observations were carried on under conditions carefully regulated to preclude error, and they are certainly full of suggestion to any one interested in the phenomena presented under fever, and what medical man is not? They point strongly to the fact which is so at one with all our ideas of heat as a mode of motion, that in all work done, whether it be the drawing of a train up a grade, the changing of water into steam, or the building of a cell, heat is used up, or changed into some other form of energy.

This subject lies at the root of a large amount of the disease we are called upon to treat from day to day. It is to be hoped, then, that that amount of attention may be given to it which it deserves, and that in the near future the question may be definitely settled.

### LAPAROTOMY EPIDEMIC.

Under the above title the *Medical Press and Circular* has in a leading article felt itself constrained to make a decided stand against the frequency with which this operation is performed in England. The article grew out of a statement made by Dr. Inlach at a recent meeting of the Liverpool Medical Institute, that every Monday, his receiving day, out of ten women his nurse picked, he found seven requiring abdominal section and "spaying." As a result of that article, at a

crowded meeting of the Liverpool Medical Institute, held on the 4th of February, to discuss the subject, Dr. Gurnsdale proposed the following resolution, seconded by Dr. John Cameron, Senior Physician to the Royal Southern Hospital, and which was unanimously carried: "That in view of the large and increasing number of cases of abdominal section at the Hospital for Women in this city, as shown in the annual Medical Reports for the years 1884 and 1885, this meeting is of opinion that a select committee should be appointed for the purpose of investigating the grave questions of practice and ethics involved in the performance of these operations, and that the following gentlemen form the committee: Dr. Nevins, president, Dr. Cameron, Dr. Waters, Mr. Bickersteth, Mr. Banks, Dr. J. H. Wilson, Dr. M'Fie Campbell and Dr. Alexander." As it was more than hinted at a previous meeting of the Institute that "women are spayed without being told what the nature of this operation of spaying is, and the position in which they will be placed by it," the remarks of our contemporary appear to be well timed.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.—Following is a list of successful candidates at the college of Physicians and Surgeons of Ontario examinations:

*For Primary.*—G. Acheson, W. Armstrong, A. E. Ardagh, L. Ault, C. N. Anderson, J. Appelle, O. R. Airson, J. W. Begg, A. D. Barnett, George Bell, A. Bradford, J. J. Brown, S. G. T. Barton, G. H. Bowlby, A. E. Bolton, R. A. E. Burns, E. Bromley, Agnes D. Craine, J. M. Cameron, Susanna Carson, D. Cameron, E. P. Campbell, L. F. Cline, S. Cummings, D. M. Campbell, G. A. Cassidy, J. G. Creegan, D. A. Dobie, W. H. Dawson, W. H. Downing, J. M. Eaton, A. J. Errett, C. R. Francy, A. J. Fisher, J. G. Ferguson, G. A. Fere, A. Forin, J. Galloway, A. D. Graham, M. Gallagher, T. H. Holsted, A. N. Hotson, L. J. Hixon, R. R. Hopkins, J. W. Hunter, J. F. Hart, W. H. Harris, J. A. Hamilton, C. James, G. F. Jones, D. A. Kidd, C. J. W. Karn, C. B. Langford, T. H. Little, A. Lawson, A. E. Lackner, B. Lammiman, Annie Lawyer, M. Maybee, W. H. Merritt, J. A. MacMahon, J. E. Maybee, D. C. Meyers, Mary B. MacKay, P. MacNaughton, J. H. McCassey, E. A. McGrath, J. B. H. McClinton, P. McLaughlin, L. G. McKibbin, C. D. McDonald, D. P. McPhail, A. W. McCordick, J. A. McDonald, D. R. McMartin, T. G. McGannon, J. A. Neff, W. Newell, A. Ochs, J. A. Palmer, A. F. Pirie, J. Proudfoot, A. R. Pyne, R. P. Pattee, J. W. Rowan, J. L. Reeve, T.

M. Robinson, J. O. Reaume, P. J. Scott, G. S. Stockton, J. R. Shannon, J. C. Smith, J. A. Scott, W. A. Shannon, A. J. Stevenson, M. Steele, T. Scales, J. W. Shillington, A. T. Tufford, O. Taylor, M. Tovell, C. A. Toole, A. F. Vrooman, T. P. Weir, W. J. Welsh.

*For Final.*—F. Beemer, L. Brock, G. M. Brodie, R. M. Bateman, F. H. Brennan, E. Bromley, H. S. Birkett, W. C. Beaman, H. E. Burdett, J. M. Conerty, W. P. Caven, G. R. Cruickshank, J. M. Cleminson, J. P. Casselman, C. Collins, J. B. Caruthers, L. F. Cutten, J. I. Cassidy, G. A. Cassidy, L. F. Campbell, W. F. Cale, C. R. Cuthbertson, J. F. Campbell, J. G. Creegan, S. S. Cornell, H. E. Drummond, D. Dunton, G. J. Dickison, W. G. Dow, W. Dow, M. L. Dixon, A. A. Dame, A. B. Eadie, jr., A. B. Eadie, sr., A. H. Edmison, W. M. English, E. H. Earl, A. Ego, W. H. Fox, J. W. Fraser, D. E. Foley, J. M. Forster, A. Forin, D. M. Gordon, T. D. Galligan, J. H. G. Grant, R. Gibson, Wm. Giles, J. W. Hunter, R. Hillier, W. C. Heggie, George Hunt, J. W. Hart, W. W. Hay, W. B. Hopkins, J. H. Hamilton, J. A. Hamilton, F. C. Heath, J. E. Hanna, P. H. Hughes, D. R. Johnston, D. W. Kester, W. J. Logie, W. Lasgie, T. C. Lapp, M. Mather, J. C. Moffat, D. E. Mundell, S. J. Mellow, J. C. McAlister, T. McEwan, H. A. McCallum, D. McEdwards, E. McLaughlin, J. C. McCabe, George McKenzie, W. H. McKague, A. F. McVety, T. G. McGannon, C. T. Noecker, W. R. Nicholls, J. Olmsted, A. B. Osborne, P. H. Orton, J. W. Peaker, R. P. Pattee, J. L. Reese, A. B. Riddall, W. A. Richardson, L. M. Robinson, J. O. Reaume, C. M. Sanford, George Sanson, J. J. Soden, J. P. Shaw, D. Storms, J. M. Shaw, H. C. Scadding, A. F. Tracy, J. A. Tuck, C. A. Toole, S. West, R. J. Wilson, E. J. Watts, R. West, F. Winnett, G. H. Wilson, W. J. Weekes, E. W. Wright, W. H. Waddell.

VICTORIA UNIVERSITY.—The following is a list of the successful candidates in Medicine at this University:—M.D. and C.M. N. Aikins, R. M. Bateman, G. M. Brodie, E. Bromley, J. A. Carbert, J. Caven, J. F. Campbell, G. R. Cruickshank, C. R. Cuthbertson, W. Dow, D. Dunton, W. G. Dow, W. English, E. C. Eschelby, J. Forster, W. H. Fox, O. Grain, W. D. Green, J. A. Harvie, A. O. Hastings, W. C. Heggie, R. Hillier, C. Hodgetts, W. B. Hopkins, G. Hunt, S. J. Jones, A. P. Knight, J. Leeming, W. J. Logie, J. M. MacCallum, T. J. McDonald, G. McDiarmid, T. McEwan, J. M. Nairn, H. Noyes, J. F. Orr, J. Rea, A. B. Biddell, G. Soutan, W. B. Thistle, A. F. Tracy, W. R. Watson, S. West, R. J. Wilson, R. J. Hood, W. A. Young.

M.D.—H. Bourbonnais, F. P. Canac-Marquis, A. Cheval, O. Clouthier, H. Dauth, A. Elfe, — Grenier, J. E. Grignon, M. Gervais, H. Hervieux,





and Sir Henry Thompson in the prevention of calculous disease and the prophylactic treatment of gravel. Löschner, Helft, and Mosler speak highly of its use, combined with suitable exercise and diet, in the torpid forms of struma, and in scrofulous children. The opinion of these authorities is likely to reinstate Friedrichshall as a favorite laxative."

**ONTARIO MEDICAL ASSOCIATION MEETING.** The following is the list of papers received by the meeting of the Ontario Medical Association up to time of going to press (which we do this month much earlier than usual). Many more, no doubt, will be in hand before the meeting on next Wednesday and Thursday, June 2nd and 3rd. The meeting will be held in the theatre of the Normal School, St. James' Square, and will be open at 10 o'clock, sharp: Dr. Tye, of Chatham, President. Dr. Reeve, "Inflammation of the Frontal Sinus"; Dr. Ferguson, "Fifty cases of Chorea in the Lower Animals—experimentally produced"; Dr. McKeough, Chatham, "The Influence of Malaria and Quinine upon Pregnancy"; Dr. Turver, "Treatment of Ante-versio-uteri"; Dr. Hunt, Williams-town, "Treatment of Laryngeal Diphtheria"; Dr. Blackstock, Thorold, "Intra-cranial Injuries"; Dr. Howe, Buffalo, "Bacteria and the Eye"; Dr. Campbell, Seaforth, "Placenta Prævia"; Dr. A. H. Wright, "Secondary Puerperal Hemorrhage"; Dr. C. W. Covernton, ———; Dr. McFarlane, "Surgical Treatment of Diphtheritic Croup"; Dr. Forin, Melrose, "Medullary Carcinoma of Liver"; Dr. Oldright, "Two or three points in the treatment of Colles's Fracture"; Dr. Palmer, "Diseases of the Eye in Pregnancy"; Dr. Henderson, Kingston, "Glio-sarcoma, involving Pituitary body"; Dr. Anglin, Kingston, "Casts of large Urinary Calculi"; Dr. Dupuis, Kingston, "Case of Multiple Hepatic Abscess, with Petrification of the Gall Bladder," also, "Case of Congenital Imperforate Rectum and Anus"; Dr. McKinnon, Guelph, "Some details on Ovariectomy"; Dr. Oakley, Streetsville, "Observations on the Repair of Nerve Tissue."

**A TEST FOR SUGAR IN THE URINE.**—A Philadelphia correspondent of the *Atlanta Medical and Surgical Journal* states that it might be of interest to mention a convenient substitute for Fehling's

solution in testing for sugar in the urine. The ordinary solutions deteriorate on keeping, and are liable to throw down the sub-oxide of copper themselves if they have not been freshly prepared. Prof. Holland, in his lectures on chemistry, at Jefferson Medical College, gave the following test fluid, which is very efficient, is easily prepared, and is not spoiled by keeping:

**GLYCERINE CUPRIC SOLUTION.**

R Cupric sulphate . . . . . 5j  
Glycerine . . . . . f 5j

To make the test add five drops of this solution to one drachm of liquor potassa, in a test-tube. Boil a few moments to test the purity of the fluid: should it remain clear, then add a few drops of urine. If glucose be present in quantity, there is at once thrown down a red precipitate, just as in the ordinary Fehling's test. To detect minute amounts of sugar, not shown by above procedure, after making the test as above, add half a drachm of urine: boil and set aside. If sugar be present, even in very minute quantity, the liquid, as it cools, will turn to an olive green color and become turbid.

**REMOVAL OF FOREIGN BODIES FROM THE EAR.**

Jonathan Hutchinson, in the *Br. Med. Jour.*, says:—I have never, since I was a student, used either forceps or scoop; and, for the purpose of extracting hard bodies from the ear, I hold that they are most dangerous. With a flexible silver wire loop, or if need be, with two placed at right angles, I have repeatedly succeeded when all other means had failed. Thus, not only is the loop quite devoid of danger, but it is both more easy of use and far more efficient than any other method. It is impossible that it can injure the membrana tympani or the walls of the canal. The method of procedure is, after having put the patient under an anæsthetic, to introduce the loop gently into the ear, and turn it about until it is believed to have got behind the foreign body. This it will often do at once; but sometimes a little patience is necessary. In one instance I took out a piece of heavy lead in this way with very little trouble, using two loops at right angles with each other. The simplicity, safety, and efficiency of the method make it desirable that it should be better known.

**THE TREATMENT OF HÆMOPTYSIS.**—Dr. Horace

Dobell recommends the following prescription for the reasons given :—

R	Ext. ergotæ . . . . .	5ii
	Acidi gallici . . . . .	5i
	Mag. sulph. . . . .	5p
	Acid sulph. dil. . . . .	5i
	Inf. rosæ acidi ad. . . . .	5viii M

SIG.—Take two tablespoonfuls every two hours. The ergot contracts the capillaries; the gallic acid is an immediate styptic; the Epsom salts relieves congestion; the digitalis steadies the heart; the sulphuric acid is also a styptic, and the infusion of roses is the menstruum for the administration of the other drugs.

CAUTION IN THE USE OF IODINE COLLODION.—The application of this mixture has not been unattended with considerable danger—mortification, as in the case of fingers, following its use. Dr. Vogelsang has pointed out that when painted upon quite a broad expanse gangrene of the skin and sloughing may occur, and that the parts most obnoxious to its use are scrofulous or other glandular swellings in the neck. Dr. Vogelsang is of opinion that the iodine is to be considered as the cause of the gangrene. He assumes that under the impervious film of collodion, an intensified chemical action of the agent takes place, leading to the coagulation of blood in the capillaries and death of tissue.

VOMITING OF PREGNANCY.—Dr. Mendel (*Archiv de Tocol*), says he has had remarkable results from irrigation of the epigastrium with ether in severe vomiting of pregnancy. A patient not relieved by any of the ordinary remedies, found immediate cure by this treatment.

THE ACTION AND USES OF CHLORATE OF POTASH.—Dr. Von Mering, as the result of experiments with this drug, holds that the following considerations should guide us in the administration of this remedy: First, the salt should be given after meals; second, quite an interval should occur between the several doses; third, the salt should not be given in high fevers on account of the diminished alkalinity of the blood; nor in respiratory trouble, such as emphysema, pneumonia, and in the dyspnoea attendant upon obstruction of the larynx by croup and diphtheria and the

cyanosis of valvular disease of the heart; a contra-indication exists also in renal mischief attended with diminished excretion.

HYOSCYAMINE IN CHOREA.—Dr. Da Costa recommends hyoscyamine in chorea in the following dose: 1-200 of a grain three times a day, the dose being doubled if necessary. He records a case treated in the Pennsylvania Hospital of a boy eleven years of age suffering with chorea to a degree which rendered him completely helpless; he was unable to walk or feed himself, and he had not sufficient control over his powers of speech to convey even the nature of his wants. In four days after the administration of the drug he was able to walk about the wards, and his condition underwent steady improvement, until, three weeks from the date of admission, his muscular system had regained its normal condition, and locomotion was in every way natural.

BRAIN SURGERY IN THE STONE AGE.—Professor Victor Horsley, of London University College, recently delivered a lecture to the Medical Society on "Brain Surgery of the Stone Age," in which he showed evidence of operations having been performed upon the skulls of men living at that time. He exhibited photographs of skulls on which trephining had been performed. Considerable discussion took place as to whether these openings are trephine-apertures or not. The lecturer pointed out the fact that these openings were in most cases found in that part of the skull over the motor area, and suggested that the operations might have been performed chiefly for traumatic epilepsy.

NEW YORK POLYCLINIC.—The Summer Session of the New York Polyclinic begins June 2nd, and ends September 11th. The past session was very successful, having had the largest class of practitioners ever registered in any school in the United States. A large number of Canadian graduates have attended the clinics during the past, and the number bids fair to increase. For the practitioner who has not time to visit the hospitals of Europe, this institution offers a valuable opportunity for clinical work. The fee for the whole course (Pathology excepted) is seventy-five dollars.

CHANGES IN TRINITY MEDICAL SCHOOL.—Dr. Covernton, in addition to his usual course in

Sanitary Science, will give a short course of lectures on the Theory and Art of Prescribing.

Dr. J. L. Davison takes the chair of *Materia Medica* and Therapeutics *vice* Dr. Kennedy resigned.

Mr. Shuttleworth will give a full course on Practical Pharmacy, so as to meet the requirements of the Medical Council and other examining bodies.

**TORONTO UNIVERSITY.**—The following gentlemen have passed their examination in this University: M. B. Gold Medal, G. A. Peters, Starr Gold Medal G. A. Peters. Silver (1) C. T. Noecker, (2) D. R. Johnston, A. W. Bigelow, J. C. Carlisle, W. P. Cavan, H. J. Hamilton, D. McKenzie, J. W. Mustard, S. G. Parker, J. W. Peaker, O. W. Peaker, G. Weld, J. Macoun, H. E. Drummond, W. A. Richardson, W. R. Watson.

*Scholarships First Year*—J. H. Collins, G. N. Waite. *Second Year*—(1) J. Galloway, (2) G. A. Féré. *Third Year*—A. Eggle, J. Olmsted.

**WOMAN'S MEDICAL COLLEGE, TORONTO.** At the Woman's Medical College, Toronto, at the 1st year's Examination, Miss Jennie Carson was the Blake scholar; in the 3rd year, Miss Alice McLaughlin was the Cameron scholar. At the Trinity University, Primary Examination, 2nd class Honors were obtained by Miss Jessie Carson and Miss Mary McKay.

**BRITISH COLUMBIA MEDICAL COUNCIL FOR THE CURRENT YEAR.**—President, Dr. Powell; Vice-President, Dr. C. N. Trew; Treasurer, Dr. J. C. Davie; Registrar and Secretary, Dr. G. L. Milne.

**CANADIAN MEDICAL ASSOCIATION.**—We wish to call attention to the meeting of the Canadian Medical Association, to be held in Quebec on the 18th and 19th August next. A very successful meeting is anticipated. Any member, desirous of proposing any alterations in the By-Laws should at once inform the Secretary, Dr. Stewart, of Montreal, of such proposed meetings.

**ONTARIO VACCINE FARM.**—We beg to call attention to the Ontario Vaccine Farm recently established in Palmerston, Ont., under the superintendence of Dr. Stewart. This establishment is subsidized by the Ontario Government, and under the

supervision of the Ontario Board of Health. We commend it to the attention of the profession in Canada.

**FEMALE PHYSICIANS.**—The College of Physicians and Surgeons of Edinburgh and Glasgow, have decided to allow women to take the conjoint examinations, and to grant the "triple qualification" in Medicine, Surgery and Midwifery.

**PERSONAL.**—Dr. F. C. Heath, President of the Alma Mater Society, of Queen's University, has commenced the practice of his profession in Brantford.

**NASAL HEMORRHAGE.** Johnathan Hutchinson says that nasal hemorrhage may be checked in nearly every case, by immersing the feet and legs up to the knees, in water as hot as can be well borne.

**BRITISH DIPLOMA.** Dr. R. N. Fraser of Queen's was admitted member of the Royal College of Surgeons, England, on 19th April.

**CORONER.**—Dr. J. Sinclair, of St. Mary's Ont., has been appointed coroner for the Co. Perth.

**ERRATA.**—By mistake, the name of Dr. Smith was omitted from the list of graduates in our last number.

For a case of *gonorrhoeal rheumatism*, Prof. Da Costa directed that blisters be applied around the joint, and that the patient take a capsule containing  $\frac{m}{v}$  of the oil of sandal-wood, four times a day.

It will be of interest to the readers of the LANCET to know that Dr. Henry, of Orangeville, was elected to fill the vacancy in the Medical Council of the Saugeen and Brock Division.

## Notes, Queries and Replies.

Will one of the correspondents of the CANADA LANCET state what is *laitière*, as it is called by Parisian ladies? My only knowledge of it is that it is supposed to give a softness to the texture of the skin (hence, I presume, its name. Fr. *lait*, milk) and a delicacy to the complexion. It is said also to alter the shape of the features. I am anxious to know what it is and how it is used. Dunglison makes no mention of it at least with this name.

T. E.

## Books and Pamphlets.

**URINARY AND RENAL DERANGEMENTS AND CALCULUS DISORDERS.** Hints on Diagnosis and Treatment. By Lionel S. Beale, M.D. Philadelphia: Blakiston, Son & Co.

He who takes up Dr. Beale's book will experience no inclination to lay it aside till he has read every page of it, for the further he travels with the author the more disinclined will he be to part company with so instructive a companion. As we read along we have marked many parts for perusal. With regard to the large secretion of urea in fevers, Dr. Beale says, page 33. "The large proportion of urea excreted in fevers and inflammations has been supposed by some authorities to be proof of excessive oxidation, and to be necessarily connected with the high temperature of the body. In spite of the blood being stagnant in the vessels and the air-cells of the lungs choked up, this ill-considered theory has been forced upon us, that it will probably be some time before any view more in accordance with well known facts will be accepted." On page 37 we have a warning as to the discovery of sugar in the urine when no sugar is really present. The reaction with Trommer's test, or Fehling's solution being due to "urea or some other constituent." It is impossible in a necessarily limited notice to draw attention in any adequate manner to the many important matters discussed in Dr. Beale's book, we feel therefore that we cannot do better than to heartily recommend it to the careful perusal of our readers; and we feel sure that the book should find a place in the library of every practical physician.

**A MANUAL OF OPERATIVE SURGERY.** By Lewis A. Stimson, B.A., M.D., surgeon to Bellevue Hospital. Professor of Clinical Surgery in the University of New York, etc. Second edition. 342 illustrations. Philadelphia: Lea Brothers & Co. Toronto: Williamson & Co.

This is a deservedly popular "Manual." Dr. Stimson has been a close observer, and is a fine practitioner. His descriptions are clearly made, and his selected operations are always the choicest. His teachings, as set forth in this book, will serve as a faithful guide to the practitioner who may at any time be called on to operate. There is no attempt at an exhaustive treatise on general surgery;

but whenever he branches off on his chosen topic, his diagnostic hints are well put and reliable. We recommend the book without reserve.

**FRACTURES AND DISLOCATIONS.** By T. Pickering Pick, F.R.C.S., Surgeon to, and Lecturer on Surgery at St. George's Hospital. Member of the Court of Examiners, R.C.S., England; 93 engravings. Philadelphia: Lea Brothers & Co. Toronto: Hart & Co.

The name of the author is so well and favorably known to medical men, that the work hardly needs a notice. The object of the author has been to present a concise and practical treatise on the common fractures and dislocations, their causes, diagnosis and treatment. The scope of the work is not large, and while it is essentially clinical, we notice the absence of certain points which we think should have found a place in its pages. The rules laid down are concise, and will be of value to the student and young surgeon, as they have been formed on the author's experience in the words of St. George's Hospital.

**A MANUAL OF AUSCULTATION AND PERCUSSION.** By Austin Flint, M.D., L.L.D., late Professor of Medicine and Clinical Medicine, Bellevue Hospital Medical College, etc. Fourth Edition revised and enlarged. Illustrated. Philadelphia: Lea Brothers & Co. Toronto: Hart & Co.

**LOCAL ANÆSTHESIA.** By J. Leonard Corning, M.D., Physician to the New York Neurological Infirmary, etc. New York: D. Appleton & Co. Toronto: Williamson & Co.

**OPERATIVE SURGERY OF THE HUMAN BRAIN.** By John D. Roberts, A.M., M.D., Professor of Anatomy and Surgery to the Philadelphia Polyclinic, etc. Philadelphia: P. Blakiston Son & Co. Toronto: Hart & Co.

**ELEMENTS OF INORGANIC CHEMISTRY**; descriptive and qualitative. By James H. Shepard, Instructor in Chemistry, Ypsilanti High School. pp. 366. Boston: D. C. Heath & Co.

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## Births, Marriages and Deaths.

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**WALLACE—LESLIE.**—At Hamilton, Dr. R. R. Wallace, to Maggie A., eldest daughter of James Leslie, Esq., M.D.

**EDGAR.**—On 28th April, the Rev. James Edgar, M.D., of Toronto, aged 63 years.

# THE CANADA LANCET.

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## Original Communications.

### ACUTE SUPPURATIVE HEPATITIS, CONSEQUENT UPON COMPLETE OBLITERATION OF THE GALL BLADDER.

BY T. R. DUPUIS, M.D., PROF. OF ANATOMY, QUEEN'S COLLEGE, KINGSTON.\*

GENTLEMEN, —The following case is of peculiar interest, on account of the part implicated, as revealed by post mortem examination : the length of time which a man may live without a gall bladder, and the few morbid symptoms which such a condition manifests. I had known the individual of whom I write for perhaps over thirty years, and during that period I had always regarded him, and he had been regarded by others, as an average healthy man. He was a farmer, and consequently had plenty of out-door exercise and coarse healthy food ; and he belonged to that peculiar class of people, who, although they do a sufficient quantity of work, are never apt to hurt themselves by over-work. There was nothing in the situation of his home, or in his mode of home-life, differing from that of other farmers around him : he lived, in fact, "a quiet uneventful life." A tavern was kept nearly opposite to his house—the house in which he was born and lived the whole of his life-time : he was far from being, what in common parlance is termed "a drunkard," yet he did not object to the taste of beer or whiskey ; and it is doubtful if ever a day passed without his having "wet his whistle" with one or both of the seductive beverages.

He was a man of medium size, light-complexioned, and spare in body, and for a few years back had seemed to me to wear a sallow, worn, and somewhat cadaveric look, although he made no special complaint of being in any way unwell.

When I made the post mortem examination, after having discovered the condition of the liver and its appendages, I inquired particularly of his wife of what he complained whenever he did make complaints. Her answer was to the effect that he scarcely ever made any complaint of being sick, excepting that occasionally, during the last nine years, he would have what they called "bilious attacks," during which attacks he would complain of pains across him, turn sick at his stomach and generally vomit a little. In a short time this state of affairs would pass away, and he would again return to his accustomed state of health. None of his neighbors or acquaintances had ever heard him complain of being sick, and they all looked upon him as healthy, tough and "wiry," equal to, if not beyond, the average of men.

*Symptoms during sickness.* —For these I am chiefly indebted to Dr. J. W. Patterson, of Harrowsmith (now of Toronto), as he was the regularly attendant physician, and I was present only in consultation with him. His report is as follows : (G. P., æt. 48 : habits regular : used tobacco largely : consumed regularly every day more or less spirituous or malt liquors : had generally a good appetite : rather inclined to constipation : was able to attend to his business as a farmer constantly : although for the last eighteen or twenty months his appetite and strength had not been entirely up to the mark. He was called to see him on the night between the 4th and 5th of March, and found him suffering from symptoms of a "heavy cold," *i. e.*, pains all over the body, severe in the back, and more especially in the lumbar region : urine scanty, very high colored : slight thirst : tongue slightly coated, but red : temperature about 100°, and great restlessness.

Doctor Patterson ordered some hot applications to the back, gave a mild diuretic and a Dover's powder to ease pain and produce diaphoresis, and procure rest. Being called again on the 7th of March, he found quite a different set of symptoms. There was pain in the epigastric and right hypochondriac regions : severe chills occurring at irregular intervals, from two to four times in the twenty-four hours : constipated bowels, with nearly a porter-colored urine : temperature 100.5° : complete anorexia ; occasional vomiting, with soreness on pressure over the region of the stomach and liver : pulse about 96. The doctor diagnosed cir-

\* Read before the Ont. Med. Ass'n, Toronto, June, 1886.

cumscribed peritonitis, with slight involvement of the liver, and treated him accordingly. On the 10th of March I saw him with Dr. Patterson, and found him in the condition last described, as his symptoms had undergone no change. In addition to the symptoms already detailed, I noticed that he coughed hard and frequently, but the most minute examination failed to detect anything more than the crepitation of bronchial mucus such as might be produced by extraneous irritation.

According to the entry made in my day book at the time I find that I diagnosed acute hepatitis with involvement of the upper peritoneal surface of the organ, being assisted in this by the acute pain which he suffered in that region. On the 12th of March I saw him again with Dr. Patterson, but I could perceive no change except increased weakness, the chills were continuing violently two or three times in the 24 hours, and his general suffering, as shown by his extreme restlessness and jactitation was extreme. On the 20th of March I saw him again, and introduced a hypodermic syringe needle into the liver to ascertain the presence of pus; but as one of the small abscesses did not happen to be punctured, no pus was obtained. A day or two afterwards Dr. Patterson introduced the needle again and obtained a minute quantity of pus; this confirmed our diagnosis, namely, that he had pus in the liver, but in what condition it existed was not so easily decided. There was no fluctuation to indicate an abscess of any size, and our conclusion was that the pus existed between the peritoneal layers in front of the liver. How correct we were the sequel will show.

Two days after this he died, and we made a post mortem examination.

*Post-Mortem Appearances.*—Abdomen flat; slight prominence in region of liver; body greatly emaciated.

On opening the abdomen and bringing the liver into view, signs of inflammation were distinctly visible. The peritoneum covering the liver was inflamed, and covered with a thin layer of pus; the inflammation extending over the whole front and upper surface of the liver, and upon the under surface of the diaphragm for a short distance, and down the lesser omentum on to the anterior wall of the stomach: the peritoneum lining the abdominal wall over the liver was inflamed, but the inflammation was not at all general. The liver its-

self was considerably increased in volume, and through its peritoneal covering appeared numerous projecting pustules of sizes varying from that of a mustard seed to that of a pea. On removing the peritoneal covering of the liver pus oozed from each of these various little abscesses, and the organ itself was a much darker red, and more friable than in health.

On raising up the liver to remove it from the body a peculiar shaped stone broke loose and fell back upon the intestines; one of the gentlemen assisting at the autopsy picked it up and exclaimed, "What is this!" We looked at it for a moment, but did not attempt to explain just then; after raising the liver high enough to get a view of its under surface, the first thing that struck our notice was the absence of a gall bladder; the right and left hepatic ducts were there, and the ductus communis choledochus, but the cystic duct and gall bladder were not. The hepatic ducts and common bile ducts were all patent, the two former being somewhat enlarged, and containing bile mingled with pus; the cystic duct, as already stated, was obliterated so that the bile passed directly downwards from the hepatic ducts into the common bile duct; the larger branches of the hepatic ducts on being cut across, poured out the same mixed fluid of pus and bile that came from their larger portions, and such a condition of affairs seemed to continue into their smallest ramifications.

The fissure for the gall bladder was marked by a deep narrow groove, into which this stony formation exactly fitted, and which explained the nature of the latter; there was nothing abnormal in the formation of the other fissures or lobes of the liver, only that its whole under surface was studded with various sized abscesses. On cutting through the substance of the liver in every direction the cut surfaces exhibited abscesses varying in size from a currant to a cherry—the largest perhaps being an inch in diameter—filled with creamy looking fluid pus. The lungs, pancreas, and spleen, looked healthy, and the stomach had not suffered except from inflammation of a part of the peritoneal coat on its anterior aspect. The cause of this condition is to me very obscure. The state of the ducts—filled with pus and bile—and the formation of this monstrous biliary concretion would place this case in that somewhat doubtful class known as "biliary abscesses."



Ziegler's Pathological Anatomy states that "when the biliary channels are somehow diseased, so that bile is retained and stagnates within them, concretions may be formed, and these appear to favor the entrance of noxious matter into the liver." Symptoms of these biliary abscesses are the mingling of pus with bile or with biliary concretions; and when the abscess lies immediately beneath the serous membrane the latter is more or less intensely inflamed.

This case fulfilled all the foregoing conditions, and hence the probability is that the cause was in the liver itself and in the quality of the bile which it secreted.

A physiological fact is here worthy of note, namely, the length of time during which a person may continue in apparent good health without a gall bladder—with the bile passing directly from the hepatic ducts into the ductus communis cholecdochus. This complete petrification of the gall bladder must have been a long time developing, for it could not possibly have occurred suddenly. The probability is that it became gradually filled with gall stones, and that these were in time cemented together by a continued secretion of matter similar to the gall stones. I had in my possession once a gall bladder packed full of gall stones—92 in all—and fitted to each other by angles and facets as perfectly as the bones of the wrist or ankle are fitted. A few years longer of life would doubtless have cemented them together into one piece, and then there would have been a condition similar to that which I have brought before you to-day.

### EXTIRPATION OF UTERUS.

BY DR. TRENHOLME, MONTREAL.

The patient is 35 years of age, and the mother of five children, the youngest eight months old. Though of a cancerous family, she is of good general health, and all her children are healthy. Her suffering began about four years ago, when uterine pain was first felt. Gradually the distress increased until about four months ago, when it became so severe as to compel her to seek medical advice. Intense pain in hypogastric and iliac regions, uterine hemorrhage and fetid vaginal discharge are the most prominent symptoms. Upon making a vaginal examination the uterus was

found freely moveable, and there was no induration of the pelvic tissues perceptible. The os uteri was excavated by an ulcer which had eaten away both lips close up to, but not involving the vaginal attachment. The cavity of the neck was funnel-shaped, the apex of the excavation corresponding to the inner os—depth of uterine cavity  $2\frac{3}{4}$  inches. The surface of the ulcer bled freely when touched, and was covered with papilliform vegetations.

As the life of this lady was extremely valuable to her young family, I hesitated to speak of extirpation of the uterus, and yet any other treatment offered but little hope for benefiting her, or lengthening her days. Removal of the diseased tissue by knife or caustic was impossible for the reasons already stated. As the patient was willing to take the risk, I felt free to do the best I could for her and removed the uterus on 15th inst.

The operation was made per vaginam, and there was scarcely any loss of blood. After cutting into the posterior *cul-de-sac*, the womb was brought backward and outside the vulva and the vaginal detachment was made segment by segment, each portion being well ligated before dividing it with the scissors. I claim that the operation was a surgical and scientific one, barring a slight incision into the bladder, the result of trying to keep too well clear of the diseased os on the left side—the wound in the bladder was closed by a single suture of shoemaker's thread. The vault in the vagina was closed by four sutures of the same material, and a bulbous drainage tube was left protruding through the wound and concealed in the vagina. The patient stood the operation well, and for two days the bladder gave no trouble—then urine found its way by the side of the drainage tube into the vagina, and as the catheter was causing some vesical irritation, and no urine passed through it, it was removed. For three days the urine gave great pain, when once more it accumulated in the bladder, and she was able to retain it until it accumulated to the extent of an ounce or more—when she passed it herself.

For the last 10 days there has been no flow through the wound, and her bladder difficulty, and in fact almost all her sufferings, have ceased. On the second day her temperature ran up to 101, and her pulse to 108. Since the fifth day both pulse and temperature have been almost normal, and for the last week quite normal. On the seventh day the patient, without permission, sat on the edge of her bed for a rest. She eats freely, sleeps well, has very little pain, and except for a

slight discharge of pus and the occasional escape of a ligature, she appears quite well.

On 16th June a number of the ligatures protruding into the vagina were removed. From this time onward she has been able to take the charge of her house and enjoys good health.

## Correspondence.

### UNPROFESSIONAL CONDUCT.

To the Editor of THE CANADA LANCET.

SIR.—Would you kindly express your opinion of the following through the columns of the LANCET :

CASE NO. I.—A medical man of many years standing in this town, whom we shall call No. 1, was attending a sick child. The father, without informing Dr. No. 1, called in a young doctor who had lately come to town, whom we shall call No. 2, who knowing all the facts of the case, unceremoniously took the case out of the hands of doctor No. 1, and neither he nor the father of the child, ever informed No. 1 that he has been discarded, but leaves him to find this out from the neighbors.

CASE NO. II. — Doctor No. 1 had a patient who came to his office for examination and treatment. Doctor No. 2 sends two distinct messages to the patient's home, asking the parents to bring their boy to his office, and he would call in doctor No. 3, a retired physician, and they would treat their boy. The parents disregarded the first request, but told doctor No. 1 that the message had been sent by No. 2. No. 2 perseveres and sends a second message, and this time succeeds. The boy is taken to No. 2, and he calls in No. 3, and between them they retain and treat the case. These medical men all met lately at the January meeting of the Med. Ass'n in this town. Numbers 1 and 2, are members in full standing, who have had no personal quarrel whatever. No. 3, is not a member. This seems to be No. One's way of doing business—as report says he followed the same practice in the place from which he came. Is it right? Is this the way to build up a practice? What means should be taken to prevent such conduct? Is it right to ask another doctor's patients on the street to come into your office for examination, and to ask other doctor's families to patronize you—as

our friend has done? Is it not lowering the character and standing of our noble profession?

Yours, etc.,

Huron, May 12th.

MEDICO.

[It is to be regretted that "regulars" in the profession sometimes stoop to such practices as are given above, for the purpose of gaining a foothold in a community. While we know that the *vox populi* is not always to be trusted, we still believe that the sense of right, governing any intelligent community, will relegate such practice where it belongs, and that No. 2 will ere long reap the reward of such underhand dealings. It would appear that no steps can be taken to punish such offenders, and we would suggest a severe letting alone by his medical brethren, as perhaps the best means of bringing No. 2 to his sense of right in such matters.]—ED. LANCET.

## Reports of Societies.

### ONTARIO MEDICAL ASSOCIATION.

The sixth annual meeting of the Ontario Medical Association was held in the Normal School buildings, Toronto, on the 2nd and 3rd ult.; Dr. Tye, Chatham, president, occupied the chair, with Dr. Anrott, London; Dr. Temple, Toronto; Dr. Hillary, Aurora, and Dr. Henderson, Kingston, the vice-presidents around him. There was a large attendance present. The Secretary, Dr. J. E. White, Toronto, read the minutes of the previous year's meeting, which were confirmed. Drs. Cronyn and Tremaine, of Buffalo, Dr. Moore, of Rochester, President of the N. Y. State Medical Society, Dr. Manton, of Detroit, and Drs. Ross, Trenholme, and Rogers of Montreal were introduced as guests. Dr. Moore took occasion to utter a few words of congratulation to the profession on the high standing it has attained in this country, and to bid them beware of quackery. After a few remarks by the other guests the President delivered his address, which was received with marked interest and attention. After returning thanks for the honor conferred upon him by his election to the chair, he pointed out the advantages to be derived by the profession from such an association as this. In the great centres of medical learning the scalpel and the microscope have opened new worlds for them to conquer, and those who expect

to do much will accomplish much. Then there were the social benefits to be derived from these meetings. The profession in this province, he went on to say, is now in a very satisfactory state. Peace, harmony and progress happily characterize it. The status of the profession is immeasurably above what it was only twenty years ago. They were all proud of what had been achieved, and though they were thankful they did not desire to rest, but to steadily advance. They lived not for to-day alone, but for the days of their children also. It was their duty and their pleasure to place the society on a broader basis, to make it more thoroughly useful and to make it embrace a large number of their fellows. He suggested that efforts should be made to organize a larger number of local societies in affiliation with the association. Such societies would consolidate the profession and greatly augment the Provincial Association meeting in numbers and in useful work. He thought the changes made two years ago at Hamilton had proved satisfactory. But while providing for their own internal economy and growth, they could not forget that they had much other work to do. It was a source of much pleasure and gratification that our system of medical education is already so complete and that our graduates are second to none. There was, however, abundance of time and ability to reach still higher grades, and it was a matter of deep regret that the colleges graduate in three terms, and that our anomalous medical relations with the Mother Country oblige our council to accept three years. This matter might engage the attention of the association. It was the duty of that association to watch well the course of medical education, to suggest improvements and to let them be known for the guidance of those in authority. A standing committee representing all parts of the province, and comprised of active, well-educated men, should be appointed to carefully watch medical education, gather facts and report their conclusions. Thus the association would be the guardian and director of medical education. The University of Toronto had with liberality and wisdom opened its portals, so that students may go there for degrees without hindrance, and it bids fair to produce a majority of the best men in the future. He suggested also the appointment of a special committee on legislation to aid in procuring legislation necessary for self-improve-

ment. He believed the profession should be more largely represented in legislative halls, so that they might find assistance when required, for they were not without enemies, and self-preservation must not be overlooked. Late efforts to obtain legislation showed how weak the profession is in this respect. It was most lamentable that men holding license to practice an honorable profession degrade themselves to the lowest condition by misrepresentation and falsehood, preying upon the superstition of the ignorant and the fears of the feeble. They obtain money under false pretences, and yet are not amenable to punishment. These were registered side by side with the most honorable men, and paraded that fact to prove a character. There was no legal distinction, and none could be made as the law stands. "We are ashamed of our company," the president said, "and pray for separation." He urged the inauguration of a system of collective investigation of preventible disease. This was a work for the State, and for the whole people. He concluded with these words:—"Should harmony still reign supreme in our young association as it has done hitherto, it should progress onward and upward, achieving a rich harvest in the future, and it shall become a pillar in the temple of the history of our country to represent the power and the glory of the profession."

Dr. Gibson and Dr. Yonkers, of Belleville, presented two patients suffering from hæmaturia, and gave detailed histories of their cases. Unfortunately, after all the trouble which these gentlemen had taken to bring these patients to the city from a considerable distance, no discussion took place and other business proceeded, the President ruling that the time allowed for the opening of such discussion had elapsed.

Dr. Atherton, Toronto, opened the discussion on fractures of the thigh by reading a paper on ordinary fractures. He concluded by emphasizing the

A long discussion followed, taken part in by Drs. Oldright, MacFarlane, Ferguson, Powell, Moore, (Rochester), Tremaine (Buffalo), Carson, J. H. Richardson and McCrae.

Dr. Campbell (Seaforth), gave the history of two cases of placenta previa, and detailed his treatment.

Drs. Stanbry, Temple, Trenholme, Davison, and Canniff took part in the discussion which followed.

Dr. W. H. Henderson, (Kingston), read a paper on a case of glio sarcoma, involving the pituitary body, which had come under his notice in the Kingston hospital.

A discussion on pneumonia was opened by Dr. Gillies, of Teeswater, who read a paper on the subject. He pointed out that this disease stands fourth in the list of most fatal diseases according to returns of the Registrar-General of Ontario. He dealt with the disease and its treatment.

Dr. Geikie followed, and spoke also on its treatment.

Drs. Canniff, Smith (Seaforth), J. E. Graham, Clark (Walkerton), and Ross (Montreal), then spoke, the treatment being the main point of discussion.

Dr. McKeough (Chatham), read a paper on "The Influence of Malaria and Quinine on Pregnant Women."

Dr. Howe, of Buffalo, made a short address, and exhibited a simple apparatus to show that practitioners can with ease cultivate bacteria and and test the antiseptic power of preparations.

Dr. Teskey followed with a few remarks, showing the very great care which is necessary in making such experiments.

On the morning of the second day the Secretary read a telegram received in reply to the one which had been forwarded to the Ohio Medical Society, then in session at Akron.

Telegrams from Dr. E. W. Jenks, Detroit, and Dr. W. H. Hingston, Montreal, were read regretting inability to accept the invitation extended to them to attend the meeting.

The consideration of albuminuria was then taken up. Dr. Eccles, of London, opened the subject, which was discussed by Drs. Macdonald, Brouse, A. H. Wright, Rosebrugh (Hamilton), Temple, Ferguson, Harrison, Mitchell and Moore (Rochester). The last named gentleman spoke at length, and gave the history of many cases which had come under his care. His address was listened to with close attention, it being full of valuable information, and presented in an interesting manner.

Dr. McKinnon, of Guelph, read a paper giving the details of four cases of ovariectomy.

On the opening of the afternoon session of the second day, Dr. Arnott of London took the chair, The President, Dr. Tye, being obliged to leave the city.

Dr. W. H. Aikins exhibited a form of splint for use in fractures of the humerus. It was of simple form, being a piece of hoop iron, about twenty-eight inches in length, with ends turned, one end to be placed under the elbow, and the other to rest on the shoulder.

Dr. Dupuis of Kingston read a paper on "Multiple Hepatic Abscess," showing specimens of gall stones, also notes of a case of congenital malformation of the rectum and anus, the specimens being exhibited at the same time.

Dr. McFarlane, Toronto, gave an address on diphtheritic croup. He had had many cases under his care during the late epidemic of the disease in Toronto. The conclusion he had arrived at was that no hard and fast line could be laid down for the treatment of all cases. He objected to tracheotomy in true diphtheria.

Dr. McDonagh, Toronto, read a paper on "The identity of croup and diphtheria," in which he expressed the opinion that membranous croup and laryngeal diphtheria are the same.

Dr. Cronyn, Buffalo, gave details of an attack of diphtheria, in his own person, to show that local applications are of no use. He thought the fact that the disease is one of septic poisoning was often overlooked. The disease was constitutional. He was opposed to tracheotomy.

The discussion was continued by Drs. Aikins, Curry, of Minden. Ruttan, Palmer, McPhedran, Macdonald, of Hamilton, and Atherton, the main point receiving attention being the expediency or otherwise of the operation of tracheotomy.

Dr. Macdonald, Hamilton, presented the report of the committee on nominations as follows:

President—Dr. J. H. Richardson, Toronto; First Vice-President—Dr. Harrison, Selkirk; Second Vice-President—Dr. Brouse, Brockville; Third Vice-President—Dr. Moorhouse, London; Fourth Vice-President—Dr. Ayelsworth, Collingwood; First Corresponding Secretary—Dr. Fraser, Sarnia; Second—Dr. Harris, Brantford; Third—Dr. Aikeman, Collingwood; Fourth—Dr. Gibson, Belleville; General Secretary—Dr. J. E. White, Toronto; Treasurer—Dr. W. A. Powell, Toronto; *vice* Dr. Graham, who resigned owing to his time being otherwise fully occupied.

Additions were recommended to be made to the committees as follows, one member being dropped from each:—Credentials—Dr. Pyne, Toronto.

Legislation—Dr. Jett, Guelph. Public Health—Dr. Bryce, Toronto. Publication—Dr. A. A. MacDonald, Toronto. By-Laws—Dr. A. M. Roseburgh, Toronto, and Dr. Gillies, Teeswater. Ethics—Dr. Oldright, Toronto.

The committee recommended Toronto as the next place of meeting.

The report was adopted.

"Diseases of the Eye in Pregnant Women," by Dr. Palmer; "Secondary Puerperal Hemorrhage," by Dr. A. H. Wright," followed.

Dr. Covernton then read a paper on "Intimate Relation of General Public, Medical Profession and Local Boards of Health with Practical Sanitation."

At the opening of the Evening Session, Dr. Temple presiding, Dr. Oldright opened a discussion on Colles' fracture, giving a few points on the subject.

Dr. Moore gave a detailed account of his mode of treating Colles' fracture. His method is to place a small roll under the wrist, bind adhesive plaster round it, and place the arm in a sling, allowing the hand to hang down. The explanation was given in the doctor's lucid manner, and was listened to with close attention. The operation was illustrated on the arm of one of the doctors present.

Dr. Cameron moved, seconded by Dr. Jones, a cordial vote of thanks to Dr. Moore for his kindness in remaining over to explain his method.

The motion was heartily adopted and presented to Dr. Moore, who replied briefly.

#### ETHICS.

A report of the Committee on Ethics was presented. It recommended for revision the code proposed by Percival in 1807, which forms the basis of the American code adopted in 1847.

Dr. Mullin stated that he, a member of the committee, had not been consulted in regard to the report.

The report, being irregular, was therefore tabled.

Dr. McFarlane expressed dissatisfaction because the committee had not dealt with the matter of consultation with irregular practitioners.

After some discussion, the following committee was appointed, on motion of Dr. McFarlane, to report next year:—Drs. Graham, Sheard, Mullin, Temple, Cameron, Burns, White, O'Reilly and the mover.

On motion of Dr. Graham, the report of this committee was made the first order for the second morning of the next annual meeting.

Dr. Henderson gave notice of a motion for the appointment of a committee to consider the formation of a defence union, for the purpose of defending actions for malpractice.

Dr. Richardson, the newly elected president, then took the chair and returned thanks for his election. He appreciated the honor very highly, particularly as it had been altogether unexpected.

#### ONTARIO MEDICAL COUNCIL.

The annual meeting of the Ontario Medical Council was held in Toronto on the 8th, 9th, 10th, and 11th ult. Dr. Bergin, M. P., Cornwall, president, occupied the chair, and the following answered to their names:—Dr. Bray, Chatham; Dr. Buchan, Toronto; Dr. Burns, Toronto; Dr. Cranston, Amprior; Dr. Day, Trenton; Dr. Edwards, London; Dr. Fenwick, London; Dr. Fowler, Kingston; Dr. Geikie, Toronto; Dr. Harris, Brantford; Dr. Henderson, Strathroy; Dr. Henry, Orangeville; Dr. Logan, Ottawa; Dr. Moore, Brockville; Dr. Orr, Maple; Dr. Philips, Brantford; Dr. Roseburgh, Hamilton; Dr. Russell, Burbank; Dr. Ruttan, Napanee; Dr. Williams, Ingersoll; Dr. Wright, Toronto; Dr. Campbell, London; Dr. Grant, Ottawa; Dr. Husband, Hamilton; Dr. Vernon, Hamilton.

After the president's address, the following officers were elected for the ensuing year:—

President—Dr. H. H. Wright, Toronto; Vice-President—Dr. Henderson, London; Registrar and Secretary—Dr. Pyne, Toronto; Treasurer—Dr. W. T. Aikins, Toronto; Solicitor—B. B. Osler, Q.C.

On the motion of Dr. Geikie, seconded by Dr. Fowler a resolution, expressing a sense of the loss sustained by the Council in the death of Dr. R. Douglas late representative of the Saugeen and Brock Electoral Division, and also tendering to the friends of the deceased the sympathy of the Council, was agreed to.

The standing committees were then struck as follows:—

Registration—Drs. Roseburgh, Fenwick, Orr, Russell, Campbell and Bergin.

Rules and Regulations—Drs. Day, Burns, Campbell, Fowler and Williams.

Finance—Drs. Edwards, Henderson, Philip, Russell and Ruttan.

Printing—Drs. Burns, Buchan, Vernon, Moore, and Henry.

Education—Drs. Grant, Buchan, Bray, Burns, Cranston, Day, Edwards, Fenwick, Fowler, Geikie, Harris, Husband, Logan, Moore, Williams and Bergin.

Executive—Drs. Wright, Henderson, and Roseburgh.

June 9th.

The Council met at 10 a.m. Dr. H. H. Wright, in the chair.

Dr. Williams gave notice of motion to revise the regulations affecting the appointment of examiners. The Building Committee reported that they had received no offers for the purchase of the Council building. They recommended that new and more suitable quarters be erected. This report was considered in Committee of the Whole and referred back to the committee for further suggestions. At the afternoon session the council appointed a Building Committee composed of Drs. Cranston, Day, Henderson, Bray, Wright, Burns, Buchan and Geikie. Mr. Grote, barrister, addressed the council on behalf of a gentleman seeking registration out of the ordinary course. The council then adjourned.

June 10th.

Council met at 10 a.m., Dr. H. H. Wright, President, in the chair.

The report of the Finance Committee was presented and adopted. It stated that the finances of the council were in a very satisfactory condition, and that after paying the mortgage on the building and ground a balance remained on hand of \$3,184.15. The liabilities were \$2,012.69, and the assets \$35,684.15.

Dr. Campbell moved a resolution to the effect that the council desires to protest against the provisions of the British Medical Act under which licentiates of medicine of Great Britain are allowed to practice in the Province without completing the curriculum adopted by this council.

The resolution was carried after some discussion.

The retiring president's address was now discussed. Dr. Grant leading in a powerful speech in which some of the utterances made by Dr. Bergin were sharply criticised. Dr. Edwards, Burns and others followed, and Drs. Edwards, Grant and Logan were appointed a committee to report on the retiring president's address.

Dr. Day moved, That in view of the peculiar position in which this Council is placed, in consequence of the present medical legislation in Great Britain, Drs. Grant, Logan and Geikie, members of the Council, be authorized when in England to take such measures as will be most likely to remove the disability of this Council in reference to the conditions under which members of the profession will be admitted to registration.

The motion was carried.

Dr. Grant presented the report of the special committee on the ex-president's address as follows:—

1. With reference to the published statement in the presidential address, "That matters had now taken such a shape that it was a question whether the college really is of service to the medical profession of Ontario," and "that he feared the college had not accomplished the purpose for which it was established," your committee are of opinion the college has accomplished a good work in formulating a line of medical education in keeping with the scientific advancement of the age, and one which now merits the approval of the profession and the teaching bodies.

2. That a central examining body now exists for all the medical students desiring to practice medicine and surgery in Ontario, that every care and discretion is now exercised in granting licenses to practice the profession, such as did not exist prior to the introduction of our present Medical Act and the formation of this council.

3. We are of opinion the council has thus far accomplished a good work and merits both professional and public support.

4. As to increased clinical instruction, we are of opinion such might be very judiciously carried into effect.

5. As to British legislation, we are of opinion that the growing requirements of medical education in Ontario will meet shortly with the cordial support of the Home Government.

6. They regret the absence of the past president, inasmuch as they feel satisfied he would have so qualified his address as to remove the erroneous impression which might be conveyed as to the usefulness of the Medical Council of Ontario.

The council resolved itself into Committee of the Whole on the report, Dr. Bray in the chair.

After considerable discussion by Drs. Bray, Geikie, Ruttan, Grant, and others, the report was adopted, and the registrar was instructed to forward a copy to Dr. Bergin.

June 11th.—Council met at 10 a.m.

Dr. Bray moved, seconded by Dr. Henderson, "That the present building committee with the addition of Dr. Aikins and the treasurer be appointed to take action and go on at once with the new building according to the plans presented to this Council, with such modifications as may be

deemed necessary, with power to raise the necessary funds in such a way as may be desirable." Carried.

The committee as constituted consists of Drs. Burns, H. H. Wright, Buchan, Geikie, Bray, Day, Henderson, Cranston and Aikins.

Dr. Orr moved, "That the territorial representatives be increased to twenty-four, and that the Legislative Committee be instructed to obtain the necessary legislation." He said that in supporting the motion that the change would do much to extend the interest in the council, while the representatives, by reducing the area of their divisions, would be within easy distance of their constituents. The motion was referred to the Legislative Committee.

Dr. Day presented the report of the Legislative Committee, stating that the amendments to the Medical Act sought by the council had been introduced at the last session of the Legislature and read the first time, but owing to the lateness of the time when considered the further stages had not been taken. The bill was not likely to have any opposition next session.

The report was adopted.

Dr. Harris moved, that Drs. Grant and Geikie be hereby appointed representatives from the council to the British Medical Association which meets in England in August next." Carried.

A by-law was passed levying a fee of \$1 on every member of the College of Physicians and Surgeons of Ontario.

Dr. Edwards moved, "That the council express its appreciation of the honor conferred on their body by the election of Dr. Grant as vice-president of Canada to the International Medical Congress." Carried.

The case of H. E. Sheppard, who applies for permission to practice, was referred to the Executive Committee.

The report of the education committee, which was adopted, recommended the appointment of the following Board of Examiners for 1887-8:—Dr. J. Fulton, Toronto anatomy, descriptive; Dr. A. S. Oliver, Kingston, theory and practice of medicine and therapeutics and general pathology; J. McArthur, London, midwifery, operative and other than operative, with puerperal and infantile diseases; Dr. G. A. Tye, Chatham, physiology and histology; Dr. I. H. Cameron, Toronto, surgery, operative and other than operative; Dr. J. H. Wishart, London, medical and surgical anatomy; Dr. M. Barrett, Toronto, chemistry, theoretical and practical and toxicology; Dr. McKay, Ingersoll, materia medica, and pharmacy; Dr. Elliott, Orillia, medical jurisprudence and sanitary science; Dr. Linton, St. Thomas, homeopathic examiner.

After passing a vote of thanks to the chairman, the council adjourned till the second Tuesday in June, 1887.

## HAMILTON MEDICAL AND SURGICAL SOCIETY.

Regular monthly meeting May 4th. Dr. Stark, President, in the chair.

Dr. Malloch exhibited to the Society a strangulated multilocular ovarian cyst, and gave a history of the case which unfortunately proved fatal. When called to the case the patient had been suffering from Friday till Monday morning, and there was general peritonitis: a tense acutely painful tumor was to be felt on the left side of the abdomen, stretching up from the left iliac fossa to near the false ribs. He advised operative interference as the only means offering a chance of life. When the peritoneum was opened masses of thick tenacious jelly-like substance escaped with blood clots. The tumor lay so far to the left that it could only be touched—the wound was then enlarged to five inches: the tumor could not then be brought into view until some of the inflamed and distended bowels had escaped. A trocar was passed into the black tense cyst when brought to the wound but nothing flowed through it. The tumor was then slowly drawn out, and in doing so a cyst upon the anterior and superior surface of the tumor was seen discharging its contents which was similar to what had escaped from the abdominal wound. The pedicle was then untwisted and a ligature applied with the Stafford hire knot and the tumor cut away. The single ligature slipped and had to be replaced by three separate ligatures. Sponge after sponge was then removed, loaded with the jelly-like substance and blood. The patient showed signs of collapse, and washing out of the abdominal cavity could not be done. Some difficulty was experienced in returning the distended bowels. A drainage tube was left in and the wound closed with stitches very closely applied. The patient recovered from the shock, but died in 36 hours, delirious: temp. in axilla two hours before death 106  $\frac{3}{4}$ . Nothing could be sucked through the drainage tube after the first four hours, so it was removed.

He stated that this was the second case of strangulated ovarian cyst that he had met with, that out of three cases of ovarian or parovian cysts seen in two years, two of them were thus complicated. The first case of strangulated ovar-



ian cyst which was successful he had reported to the Society in 1884.

From this experience one would be inclined to infer that strangulation was not an uncommon event in the history of ovarian disease: this however is not the case as in Mr. Lawson Tait's first 100 ovariectomies he had only once met this complication, and many ovariectomists had never met with this unfortunate complication. This case he thought was peculiarly interesting: it occurred on the left side, whereas by far the greater number of cases are right-sided: to his mind it completely refuted Mr. Lawson Tait's theory with regard to the cause of the twist in the pedicle in these cases. Dr. Malloch's first case was right-sided, direction of twist not noted, but in this case the direction and degree were seen by all present. In general, as he understands it from Mr. Tait's books, the direction of the twist in right-sided cases is from below outwards to the right and then across to the left, and that the direction is given by the infringement of masses of faeces passing down the rectum. In this case the direction of the twist was from the middle to the left, and then round towards the pubis, the rectum being in its normal position. He thought the twist would have been the very reverse were it due to the passage of faeces down a left side rectum. From a diagnostic point the case was interesting as the tumor lay over the descending colon, and did not reach the middle lines, the length of the pedicle could not have been three-quarters of an inch. The patient had been operated on for ovarian disease some 14 years before by Dr. Keith, of Edinburgh. In his first case Dr. Malloch advised an operation to remove tension in the abdominal cavity affected with peritonitis, not knowing that the cyst was strangulated, and he thinks that with symptoms of peritonitis and an abdominal tumor likely at all to be removable an operation is called for.

Dr. A. Woolverton said he thought that if the operation had been performed earlier the patient might have had a better chance of recovery.

Dr. Leslie advanced a theory to account for the twist in the pedicle. He supposed the cyst had first ruptured and set up inflammation and distension of the abdomen, thus causing the twist.

Drs. Phillips, Mackelcan, Shaw and McCargow, made some remarks.

Dr. Hillyer read a medico-legal paper, bearing on a case in his practice, which was freely discussed.

F. E. WOOLVERTON, Secretary.

### Selected Articles.

#### MASSAGE AS A THERAPEUTIC AGENT.

BY WILLIAM MURRELL, M.D., F.R.C.P.

Massage is of such inestimable value in the treatment of many intractable diseases, that it is

to be regretted that so little is known about it in this country, and that it is so rarely employed as a therapeutic agent. It is often spoken of as a new method of treatment, but it has been in general use on the continent for a long time, and, more than ten years ago, received the adhesion of Billroth, Langenbeck, Esmarch, and other authorities. In a crude and primitive form, it is very ancient indeed, and is probably as old as surgery itself. Amongst the Greeks and the Romans it was extensively employed, both as a means of hastening convalescence from long tedious illnesses, and to relieve pain, and render supple, bruised or injured joints. The writings of Plato abound in references to this mode of treatment, and its virtues seem to have been very generally recognised.

It is to be feared that there is a certain amount of prejudice against the employment of massage, arising, probably, from the fact that it is frequently confounded with "shampooing" and "medical rubbing;" but it is, in reality, a scientific mode of treatment well worthy of attentive study at the hands of skilled physicians and surgeons. The literature of the subject is extensive, and it would be impossible to give, within the limits of a short article, even an abstract of it. There are several kinds of massage, but the system almost universally adopted in Germany is that associated with the names of Mezger and von Mosengeil. Mezger may be regarded as the father of the modern phase of massage, while Professor von Mosengeil, by his accurate and painstaking experiments, has done much to establish it on a sound scientific basis. Those who have studied under the last named distinguished surgeon, and have had an opportunity of seeing him practise his method, will appreciate the fact that there is much more in it than at first sight appears. It is essential for success that the various processes should be carried out systematically, and in a definite order; although, of course, the same method of treatment is not applicable to every case. Every "movement" begins and ends with *effleurage*, the palm of the hand, and sometimes the knuckles, being employed for the purpose. It is always centripetal, and is performed with considerable rapidity and force. *Pétrissage* is a more complex process, and is by no means easy to acquire, although it looks simple enough. *Fric-tion* is performed with the tips of the fingers, and is used in conjunction with *effleurage*, chiefly in the treatment of various affections of the joints. This term, which was originally introduced by von Mosengeil, is an unfortunate one, for it has nothing in common with what we ordinarily understand by friction. *Tapotement* is a kind of percussion, and may be performed either with the tips of the fingers, the partially closed hand, or its ulnar or radial border. Mezger rarely employs electrical treatment in conjunction with the manipulative processes, but von Mosengeil attaches much im-

portance to it, and, in suitable cases, uses both the interrupted and constant currents to stimulate the motor points. He dispenses with complex apparatus, and his sessions are of short duration, rarely exceeding five minutes. On the continent, the physician or surgeon is usually his own operator, it being considered inexpedient to employ, even as an assistant, anyone who has not been thoroughly and systematically trained, a process which requires, at least, two years of unremitting attention. It is known that, in many instances, incalculable harm has resulted to patients from ill directed efforts, or the selection of unsuitable cases. For the treatment of women and children, an accomplished *masseuse* is essential; but she must be well educated, and should have such a knowledge of anatomy and physiology as will enable her to carry out the instructions of the physician intelligently. It is not at all necessary that she should be physically strong, aptitude being of more importance than mere muscular strength. The hands must be soft; and, if proper precautions be taken, there is never any risk of abrading the skin.

It is no easy matter to say in what class of diseases massage proves most useful. Unfortunately, its employment has been advocated in many cases, for which it is essentially unsuited. Accurate diagnosis is of the utmost importance, and the sphere of usefulness of this remedy, will, with increased experience, become more accurately defined. My best results have been in infantile paralysis; and it was in consequence of the success achieved in certain obstinate cases of this disease, that my attention, as has been elsewhere stated, was directed to the subject. Progress is often slow, but the ultimate results are most satisfactory. The nutrition of the parts is maintained until new cells in the spinal cord take on the functions of those which have undergone degeneration, or have been destroyed. Massage is, undoubtedly, of much value in many cases of obstinate neuralgia, and succeeds admirably in some forms of muscular pain, such, for example, as those described by the late Dr. Inman, under the term "myalgia." There is a general consensus of opinion that it is well adapted for the treatment of chronic joint-affections; and most of those I saw treated by von Mosengeil, were such as would, in this country, be considered incurable, or would drift into the hands of "bone-setters." There are some diseases of internal organs in which it is, undoubtedly, useful. Not long ago, a gentleman, aged 68, came to me complaining of shortness of breath, and increasing disinclination to take exercise. He had been in business, and had led a most active and energetic life. Three or four years ago he retired, and, from that time, experienced a gradual falling off in health. His appetite was poor, his bowels were obstinately confined, and he was nervous and anxious about himself. He was found to have a loud

apex systolic murmur, and the heart's action was weak and irregular. I suggested massage, which was carried out systematically four days a week, for a period of six weeks. He improved from the very first, and, before the conclusion of the course, was better than he had been for many months. His appetite returned; his hands and feet were warmer; the bowels became regular; he slept well at night; and his spirits improved in a most satisfactory manner. In other cases of obstinate constipation, especially in women, I have known massage of the abdomen do a great deal of good.

In a well-known group of symptoms from which women frequently suffer, massage is essentially useful. I recently saw a lady, aged 45, or thereabouts, a professional singer, who was laboring under the impression that she was going mad. She was so nervous that she was quite unable to accept an engagement, although she had been constantly before the public, and had hardly missed a night for twenty years. She told me that she felt she was not to be trusted, and that, if left alone, she would do herself or her children an injury. She was afraid to go near an open window, so great was the temptation to throw herself out; and she even begged that the knives might be removed from the table at dinner. These feelings were greatly intensified after each monthly period, and she insisted that she was suffering from cancer, or some organic disease of the stomach or womb. She was restless at night, and would often get up in the early morning, and walk for hours, until thoroughly exhausted. She was given full doses of the bromides—a drachm, or more, four times a day—but with only temporary benefit. Massage was then tried; and it seemed, to use her own expression, to soothe her, and calm her, and make her forget her troubles. The case was a prolonged one, but now, at the expiration of three months, she is much better, and will soon be able to resume her professional duties. In several other cases of restlessness and inability to sleep, the same method of treatment has proved efficacious.

Dr. Graham, of New York, speaks highly of massage in the treatment of neurasthenia. He uses it for those "who, in spite of rest, change and medication, have become chronic neurasthenics, the result of business reverses, over-work, worry, loss of relatives, disappointed hopes, or as a sequel of some affection that has existed in some part of the system, but which has recovered or has become of secondary importance." These symptoms may be somewhat ill-defined; but, I have certainly found massage of the greatest use in what, for want of a better name, has been called "spinal nervous weakness," or "neurasthenia spinalis."

In the treatment of corpulence associated with constipation, massage is of much value. Some months ago I saw a lady, aged 38, who, as the result of much good living and little exercise, had

become inordinately stout. She was very short of breath, and was disinclined for exertion of any kind. She had been fond of literary pursuits, but even those had lost their charm, and were irksome to her. She was extremely irritable, and a source of trouble and anxiety to her friends and relatives. Massage was prescribed, and in two months she lost a stone and a half in weight, and improved notably in other respects.

For many forms of menstrual disturbance, massage may be safely prescribed. I recently saw a young lady, aged 19, who suffered intensely at each monthly period, the pain being so severe, that hypodermic injections of morphia had to be resorted to. Massage of the abdomen and pelvis was prescribed, and from that time there was no return of the trouble. Cazeaux has reported several similar cases, in detail. In the convalescence from acute illnesses, this mode of treatment is a great help and comfort to the patient. There can be no doubt that massage is a very valuable therapeutic agent, and is likely to yield good results in many complaints other than those I have roughly indicated. —*Brit. Med. Jour.*

## CONTRIBUTIONS TO PRACTICAL SURGERY.

BY PROF. JOHN CHIENE, ED.

*Hæmorrhoids.* The presence of internal hæmorrhoids is local evidence of a general congestion of the portal system, and only when there is great local discomfort, and after every endeavour has been made to improve the general condition of the patient by medicinal treatment, should operative procedure be undertaken. There is great difference of opinion as to the best method of treating internal piles when operation is necessary. If the ligature is used it should be soaked in a solution of chloride of zinc, 40 grs. to the ounce. It must be tied tightly, completely strangulating the pile. If the ligature is tied loosely, acute inflammation followed by gangrene is the result. Injection of 10 drops of a 4% solution of cocaine into the base of the pile before applying the ligature greatly relieves the pain. If the pile be pedunculated, its base may be constricted by simply passing the ligature round it and tying it tightly. If the pile is sessile, its base should be transfixed with a curved needle carrying a double thread, each ligature being tightly tied so as to constrict  $\frac{1}{2}$  of the base. If the base of the pile is close to the opening of the anus, the division of the mucous membrane at the verge of the anus with scissors before tying the pile assists the more effectual application of the ligature and greatly lessens after discomfort. If there is more than one pile, each must be attacked separately in this way. The ligatures being cut short, the strangulated masses

are then pushed back, and a  $\frac{1}{2}$  grain morphia suppository introduced into the cavity of the rectum. The patient's bowels should have been thoroughly emptied before operation. The diet should be very light after the operation, and it is not necessary that the patient's bowels be moved until the third or fourth day. This is best done by the administration of castor oil by the mouth, and the discomfort felt during the movement of the bowels is greatly alleviated by the injection of 4 oz. of olive oil. Many patients suffer from retention of urine after this and other operations on the rectum, and it is therefore necessary to see the patient on the evening of the operation, and if he has not made water, a red rubber instrument must be introduced to evacuate the contents of the bladder. The use of the clamp and cautery has to a certain extent displaced the use of the ligature, but in the opinion of the writer the ligature, if properly applied, is as efficient as the cautery, and is less likely to be followed by hæmorrhage. Never operate in a case of internal piles without having first satisfied yourself that the patient is not suffering from cancer of the rectum. External piles are to be treated by removal with a pair of curved scissors, the cut surface being touched with a solution of chloride of zinc, 40 grs. to the ounce.

A patient may consult you, complaining of having felt a sharp, cutting pain during the passage of a hard fecal mass. Visual examination of the anus will at once indicate what has happened. A small tumor of a bluish color is seen at the opening of the anus, where the skin and mucous membrane meet. A submucous vessel has given way, and the extravasated blood clots. This condition may be treated by fomentations and rest. After a time the clot will be absorbed, but the process is a slow one, and it is better to transfix the mass with a sharp-pointed, curved bistoury—the clot being squeezed out and the cavity touched with chloride of zinc, 40 grs. to the ounce.

*Fissure.* The pain in fissure is of a two-fold character: a sharp, cutting pain felt during movement of the bowels, and a throbbing persistent uneasiness coming on after the bowels are moved, and lasting for a variable period. The primary pain is due to the stretching of the part. The persistent after-pain is due to spasmodic contractions of the sphincter. The base of the fissure consists of muscular tissue, and free division of this muscular base relieves the symptoms, gives the part rest, and allows the ulcer to heal. Injection of cocaine into the tissue forming the base of the ulcer renders the operation painless. The division of the base of the fissure, however, does not always give relief, and in a severe case of fissure it is more satisfactory to place the patient deeply under chloroform, to introduce the thumbs within the anus and forcibly to stretch the sphincter, dividing at the same time the base of the fissure. Introduce a morphia sup-

pository after the operation, and prevent movement of the bowels for three or four days.

Division of the base of the fissure is very frequently done by introducing the finger into the anus, and then, with the finger as a guide to the upper extremity of the fissure, a sharp pointed curved bistoury is introduced at the side of the anus and carried through the base of the fissure up to the point of the finger. This method of performing the operation is dangerous, and surgeons have been attacked with syphilis in consequence of pricking the finger with the point of the bistoury. The safer plan is to lay a straight blunt pointed bistoury flat upon the finger, to introduce the finger with the bistoury in position, to feel for the upper extremity of the fissure, and then to turn the sharp edge of the bistoury towards the ulcer, the back of the bistoury lying on the finger. The knife is then carried through the base of the fissure by the pressure of the finger. The bistoury to be used, though probe pointed, must have a cutting edge to its extremity.

*Prolapsus Recti* in the child is very often a symptom of stone in the bladder. The child may be brought to you with the prolapse down for some time. It may be reduced by manual pressure, but the simplest way to reduce it is by elastic pressure with a T shaped bandage, placing a pad of cotton wool between the bandage and the prolapse. In elderly people, prolapse of the rectum is generally due to chronic relaxation of the sphincter ani, and levator ani muscles. The removal of the redundant skin around the dilated anus may assist in keeping up the prolapse. Special instruments are made for preventing its descent, but the most efficacious method is a double T bandage, with two vertical limbs, each one attached, both in front and behind, to a firm pelvic band, and crossing in the perineum over the anus. At the point where they cross, a pad of lint is interposed between the bandage and the anus.

*Fistula in Ano* The most satisfactory way to divide a complete fistula is to pass a probe from the external opening along the sinus, through the internal opening, and then by bending the probe to bring its point out at the anus. The probe is then cut out, and the septum is in this way completely divided. There is a groove in the probe which acts as a guide to the knife. Care must be taken in the after treatment by stuffing the wound, to cause it to heal from the deepest parts towards the surface.

*Bladder.* Chronic cystitis is one of the most troublesome affections that the surgeon is called upon to treat. The primary cause is often due to the introduction of organisms with an unclean instrument, and therefore in all cases in which, by the presence of increased quantities of mucus or of pus in the urine, along with frequency of micturition, a diagnosis of cystitis is made, the urine

should be carefully examined for the presence of organisms. If they are present, corrosive sublimate should be administered internally in small doses, and the bladder should be washed out with antiseptic solutions. No rule can be laid down as to the special antiseptic to be used. The great point to attend to is that the bladder be repeatedly filled and emptied until the fluid escapes free from all sediment. The best way to wash out the bladder is to introduce a red rubber catheter with a "velvet eye," and to attach to this a T tube of glass. To the vertical branch of the T an india-rubber tube four feet long is fixed, and is passed into a vessel containing the fluid to be injected. This fluid should be tepid and contain an antiseptic. To the horizontal limb of the T another piece of tubing is attached, in order to carry the fluid from the bladder. The outlet tube being pressed with the finger and thumb, the vessel connected with the inlet tube is raised, and the fluid is allowed to flow into the bladder until the patient feels slight discomfort. The inlet tube is now grasped with the finger and thumb and the fluid is allowed to escape by the outlet tube. This is repeated again and again until the bladder is thoroughly cleansed. In many intractable cases this method of treatment is not sufficient, because the bladder is an organ which is never at rest. When it is inflamed from any cause, its diastole and systole, instead of being repeated three or four times within the 24 hours, takes place much more frequently. In such cases it will be necessary to give the bladder rest, either by bladder drainage, according to the method recommended in the MED. ABS., p. 4, 1881; or should this plan fail, as it may do if there is much mucus which plugs the tube, the membranous urethra must then be opened on a grooved staff, and a tube introduced into the bladder through the wound, which allows the urine constantly to drain away as it escapes from the ureters. The tube introduced should be as large as possible to prevent any risk of blocking, and the bladder should be washed out through this tube, so as to clear away any mucus which may collect at the floor of the bladder. Such a tube may be kept in for a fortnight without risk of a persistent fistula remaining.

*Hypertrophy of the Prostate.* If a patient says he has to rise at night to make water, and that he makes water during the day with increased frequency, always be suspicious that he is not emptying his bladder completely. He makes only the overflow from a distended viscus. When there is a tendency to obstruction of the flow of the urine in consequence of hypertrophy of the prostate, there is little doubt that the occasional passage of a large-sized bougie is of value in keeping the channel patent.

*Stricture of the Urethra.* Organic stricture of the urethra is caused either by an injury to the urethra or by gonorrhoea. After a gonorrhoea

passes into a persistent gleet, the source of the discharge is generally from the urethra, in the neighborhood of the triangular ligament. This is the common situation of stricture. The patient may be brought under your notice for the first time suffering from retention of urine, or he may come complaining of a decrease in the size of the stream. The contraction of the urethra is so very gradual, that the stream may become of very small size before it attracts the notice of the patient. No method of relieving stricture is permanent, and after the urethra is restored to its normal calibre, the patient must always be informed that the occasional passage of an instrument during the remainder of his life is the only certain way of preventing a recurrence of the condition. In uncomplicated cases of stricture the treatment by gradual dilatation is the surest and safest method. In anterior strictures internal division may be adopted; in posterior strictures at the triangular ligament, if the stricture is of a resilient character, with great tendency to rapid recurrence, Holt's method may be used. If there is much perineal induration, more especially if it is complicated with perineal fistula, external division is the best remedy. These three latter ways of treating stricture are only to be used in exceptional cases. The great majority of cases of stricture should be treated by gradual dilatation. This can be done in two distinct ways. If the patient can keep his bed, a gum elastic catheter is passed through the stricture into the bladder. The size of the instrument will depend upon the size of the structure. If, for example, a No. 2 is passed, and is not tightly grasped at the strictured part, a No. 3 is passed. This may also pass easily, and not be grasped. If so, a larger instrument must be introduced. If, however, it is grasped, it is fixed to the penis with a piece of sticking plaster. During the first few hours the urine flows through the instrument, but on the following day, when the patient makes water, the urine escapes along the outside of the instrument. The instrument is now loose. By its pressure it has caused absorption of the inflammatory lymph or fibrous tissue under the mucous membrane. A larger sized instrument is then passed. It in its turn is grasped and gradually the process being repeated, a No. 12 is at last reached. The rapidity with which this point is arrived at will vary, but, as a rule, in uncomplicated cases it is generally found that each day represents a number in the size of the instruments, and in from ten days to a fortnight the urethra is dilated to its normal calibre. It is well not to stop at No. 12, but to go on to No. 14. This method of treatment requires constant confinement to bed.

The other method of treatment is intermittent. The stricture is gauged with a bougie. Let us suppose that a No. 3 can be passed. The result of the passage of this instrument will probably be

slight decrease in the size of the stream on the following day. On the third day there will be improvement; on the fourth day a No. 3 can be passed with ease. A No. 4 is then passed, and perhaps even a No. 5 can be passed. The great point to attend to is not to attempt too much at each time, but to be satisfied with the passage of one or two instruments of a larger size than the one that was previously passed. Gradually by this method the full size is reached. If the patient can keep his bed during the cure, the instruments may be passed every third or fourth day. If the patient is going about, an interval of a week between the passage of the instruments is preferable. There is much difference of opinion as to the best form of bougie to use. Many surgeons use the French bulbous-pointed flexible bougies. Other surgeons use a metallic instrument—either the cylindrical bougie with a rounded point and of equal calibre throughout, or a solid metallic instrument with a bulbous point and gradually increasing from the neck, so as to be more or less of a wedge shape. The writer prefers the metallic instruments, and if the bulbous-pointed metallic instruments are used, care must be taken not to exert any force in passing the bougie, because its wedge shape, especially as this is very gradual, greatly increases its power, and, in fact, it may be used forcibly to distend the structure. If used in this way, it does not act in the same way as the old cylindrical bougie, which is intended simply to set up a slight irritation, and cause absorption of the fibrous tissue. If the wedge-shaped bougie is used, it may not only do this, but may mechanically stretch the strictured part, and to a certain extent approach in principle to other mechanical means used.

*Retention of Urine.* (a) Retention may occur after an operation, such as ligature of internal piles. In this case the condition is a purely reflex one, and is easily relieved by the use of a large sized red rubber instrument, thoroughly purified by injecting through it a weak solution of corrosive sublimate, and anointed with a weak antiseptic oil, *e.g.*, vaseline mixed with oil of eucalyptus, half a drachm of the latter to an ounce of the former.

(b.) Retention of urine may also occur as a complication in an acute gonorrhoea. This is rare if the urethra has previously been perfectly healthy. In such cases there is a combination of acute inflammation with spasm, and every endeavour ought to be made to relieve the condition by the use of hip-baths, hot fomentations, large doses of bromide of potassium, and morphia suppositories. An instrument should only be used when these fail. A flexible instrument will not do; and a metallic instrument, which should be of large size, is necessary. The catheter should be thoroughly purified by passing through it a stream of 1 to 20 carbolic lotion; and the form of metallic catheter most

easily kept pure is that in which the portion between the eye and the point of the instrument is solid, instead of forming a little cul-de-sac, which is often very difficult to cleanse thoroughly. The spasm is overcome by gentle steady pressure. Even with the greatest gentleness there is often severe pain, and the injection of a drachm of a  $\frac{1}{4}$  solution of cocaine gives great relief.

(c) Retention of the urine may also occur in consequence of the superaddition of an acute inflammation, with spasm, to an old standing organic stricture. Here, again, the hip-bath, with the other means above recommended, should always be tried in the first instance before attempting to pass instruments; and if the surgeon has no previous knowledge of the case, and is unacquainted with the size of the organic stricture, he should not at once use a small instrument but begin with a No. 6 or No. 7; and if he fails to pass this, he may then try smaller instruments. The smaller the instrument the greater the risk of laceration of the mucous membrane of the urethra. If after a fair trial with instruments, he fails to relieve the retention, he should aspirate above the pubis, continue the use of fomentations and sedatives, and on the following day he will find either that the retention is relieved, or that he is now able to pass an instrument along the urethra into the bladder. This use of aspiration is of value. Repeated aspiration in bad cases of stricture with retention are not, however, to be recommended. In such cases there is a tight stricture, and it is best here to pass a large sized instrument down to the stricture, and the patient being tied up in the lithotomy position, to cut down on the middle line on the point of the instrument, to open the urethra, and, using a fine grooved probe, to search for the stricture; and, pass the probe along it, to divide the stricture with a narrow knife, passed along the groove in the probe. A full-sized gum elastic catheter is then tied into the bladder.

The tolerance of instrumental interference with the urethra varies very greatly in different people, and it should be a rule in practice, in cases in which the surgeon is entirely ignorant of the sensitiveness of the patient, not to pass an instrument, for the first time, in any circumstances in which the patient may be exposed to wet or cold. Before the passage of an instrument, it is well to administer 5 grains of quinine, or some of the more recently introduced antipyretics, *e.g.*, kairin or antipyrin. These remedies have an undoubted value in checking urethral fever. Their power is increased by giving the patient a drink of warm gruel immediately after the instrument has been passed. Shivering and rapid rise in temperature, after the passage of a bougie, must not be confounded with so-called "catheter fever," which has within recent years been brought prominently under notice.

(d) Retention of urine in old men is generally

due to a congestive attack of the prostate superadded to hypertrophy of the gland. Here, again, the congestion should, if possible, be relieved by hip-baths, fomentations and sedatives, and, if instrumental assistance is required, in the great majority of cases the red rubber instrument relieves the retention. If the instrument fails then a metallic instrument is necessary. In cases in which there is a distinct valvular obstruction from enlargement of the middle lobe of the prostate, the difficulty is overcome by passing a large sized gum elastic catheter with a metallic stylet *in situ* down to the obstruction. If the instrument is then withdrawn to the extent of an inch, by pulling on the stylet, the point of the catheter will rise vertically in the bladder.

(e) Retention in young children is very frequently due to the presence of a calculus in the urethra. In rare cases it may be due to malignant disease of the prostate, and sometimes it is due to abscess in the prostate. These conditions are comparatively rare.

## THE IMMEDIATE CLOSURE AND RAPID CURE OF FISTULA-IN-ANO.

BY STEPHEN SMITH, M.D.

The possibility of a prompt cure of fistula-in-ano is a great advance in the treatment of this hitherto troublesome affection. Every surgeon must have met with cases which resisted the old method, and failed altogether to heal. And even when those having a large abscess cavity finally healed after free incision, there was often a deep cicatrix, which was a source of constant irritation from the tendency to the accumulation of filth in the deep sulcus. Occasionally there was a certain troublesome defect in the action of the sphincter, which remained as a permanent disability. In these latter days of rapid improvement in the methods of operations, it has naturally occurred to many surgeons that fistula-in-ano might be treated successfully by the immediate closure of the wound, provided the track and abscess cavity were properly prepared, and then sutures were employed so as thoroughly to approximate the surface. It has been performed successfully in this country by Drs. Emmet, Weir, Lange and Chamberlain, of this city, by Dr. Jenks, of Chicago, and by several surgeons abroad. In most instances these surgeons have operated without any previous knowledge of the work of other operators. The simplicity and the success of the operation warrant the effort to give it greater prominence than it has yet received.

Attempts have been made, heretofore, to cure fistula-in-ano by incision of the track, followed by the dissection of the lining membrane, but with indifferent success. It is only when the surfaces are quite firmly brought together and maintained in apposition, that union takes place with any greater



certainly and rapidity than by the former method. My attention was first directed to this method of operation on the appearance of the first edition of Dr. Emmet's work, in 1879. I was impressed, while reading that work, with the explanations of the method of closing a lacerated perineum involving the sphincter ani, and with the accompanying illustrations. I had at that time under observation a case of fistula-in-ano, which had been laid open freely six months before, but had failed of union. The line of incision was slightly to the left of the median line, but the depth of the wound and its large granulating surfaces reminded me of some of the conditions of a lacerated perineum of long standing.

The suggestion that this wound, involving the sphincter, was amenable to a somewhat similar method of treatment was very natural. The result proved the truth of the suggestion. It was not difficult to dissect away the granulating surface, and to accurately close the wound with sutures not unlike those used for the lacerated perineum. Union promptly occurred. Since that time I have operated on a number of cases of fistula, including every variety of form, and nearly every condition of patient, with a degree of success which commends the procedure to my confidence.

The principles which should be born in mind in the operation are: 1, complete removal of the lining membrane of the fistula and of the abscess cavity which may exist; 2, accurate and permanent adjustment of the opposing surfaces; 3, through antiseptic treatment of the wound.

The details of the operation are simple, but they must vary somewhat according to the peculiarities of each case. After considerable experience, I have adopted the following plan: The patient is prepared for the operation by taking an ounce of castor-oil for two succeeding days before the operation, omitting the last day, on which he takes an opiate at bedtime. The diet should be milk. It is intended to keep the bowels quiet for four to six days after the operation. The patient being anesthetized, the parts about the anus are thoroughly washed with soap and water, then carefully shaved, and finally irrigated with bichloride solution. This douche is also thrown into the rectum and the index-finger is introduced and swept around the folds of the rectum, in order that the mucous membrane may be relieved of any matters lodged in that region. A clean sponge, wrung out of the bichloride solution and having a string attached, is next introduced into the rectum to prevent any matter from the bowel escaping and soiling the wound. The patient is placed on the back or side on which the fistula opens. If the fistulous passage is direct it is incised in the usual manner. If there is an abscess cavity this is opened to the full extent, in order to give free access to the lining membrane. The lining membrane or so called pyogenic mem-

brane, is then carefully dissected away, throughout both the cavity and the fistula. The rapid and permanent healing of the wound depends largely upon the thoroughness with which this tissue is removed. It is generally very dense, and can only be completely dissected off with a sharp scalpel or scissors cutting well at the point. In some of my early operations I resorted to the curette, and endeavoured to destroy the membrane sufficiently to secure union, but the operations were unsatisfactory till I removed it with a knife or scissors. When it is completely removed, the ragged, or thin and purple, margins of the wound are cut away so as to have clean and healthy surfaces for apposition and union. There is in some cases considerable hemorrhage from small arteries, which must all be ligated before the wound is closed. The first step in the closing of the fistula and abscess is to secure perfect apposition of the margins of the wound within the rectum. To effect this object an assistant should introduce an index-finger well into the rectum, and then, bending in as a hook, extrude the bowel which is readily effected. The whole track of the fistula is thus brought into view, and the surgeon has full control of the wound. To obtain prompt union it is necessary to evert the edges of the mucous membrane, and bring the deeper cut surfaces into contact. The success of the operation depends upon securing complete and firm closure of that portion of the fistula which involves the mucous membrane. The first sutures, therefore, should be so applied as to bring the deep surface together and evert the margins of the mucous membrane. To effect this object I take a large-sized carbolized silk ligature, or catgut prepared with chromic acid, and attach a needle having a slightly curved point to each end. These materials are preferred because they will not yield as does the ordinary cat gut, and allow the margins to separate before union takes place. One needle is now passed just above the highest point of the incision, and from a fourth to half an inch from the margins of the wound, and the thread is drawn through to its centre. The needles are then passed in opposite directions at intervals of about half an inch, in the same manner as the saddler takes his double stitch when two pieces of leather are held in a vice and united. If the fistula is simple and there is no abscess cavity, the stitches are continued to the external extremity of the incision, making a continuous suture on each side of the wound. They are now tightened sufficiently to bring the two surfaces into apposition and slightly evert the margins of the mucous membrane, but without any strain. The ends of the ligature are then given to an assistant, who by moderate traction draws the entire fistulous track outside. The margins of the wound are now nicely adjusted with a continuous suture commencing at the upper extremity of the wound. At the external extrem-



ity of the wound a drainage-tube is inserted. When the margins of the wound are closed the ends of the suture are tied. The operation is completed by passing two or three large carbolized silk ligatures entirely under the fistula, and tying them over an iodoform gauze pad rolled firmly and laid along the wound. The object of these last ligatures is to bring the deep portion of the fistula in suitable apposition. During the operation irrigation with the bichloride solution is continued, and iodoform gauze is applied as an external dressing. The sponge is finally withdrawn from the rectum, and a suppository of opium inserted. The diet should be milk, and opium should be continued daily for from four to six days to keep the bowels quiet. The patient should remain in bed, and at first should remain recumbent, with the limb straight. In some cases I have applied a binder about the hips to prevent movements, where the patients were inclined to be restless.

If there is a large abscess cavity and, as often occurs, irregular, as in the horse-shoe fistula, I have always entered the cavity at the external opening, then laid it open freely throughout its entire extent, and finally have opened the internal fistulous passage at the point where the cavity communicated with the interior of the bowel. Such an abscess presents a large, irregular, deep cavity, having an opening into the bowel sometimes on the side opposite the point where the cavity opens externally. These cases require much care, for the cavity to be closed is enormous, but they may be perfectly healed by one operation, if great pains are taken to dissect out all the false membrane, and to adjust the sutures so as to bring the surface into apposition. The internal fistulous track is closed by the same suture as the simple fistula. The abscess cavity may be closed by one of two methods: 1. The same double, continuous saddler's suture may be employed, but it should be taken farther from the external margin of the wound, in order to bring as much strain as possible on the deep parts of the wound. Upon the inside along the margin of the anus, it is well to enter the suture close to the border of the mucous membrane. This suture is continued to the external extremity of the wound. The continuous suture is then applied to the wound, and the same dressings applied. It sometimes happens that, even in the horse-shoe fistula, when the suture is finished, two or three sutures, either large thread or wire, inclosing the entire cavity, may be passed completely around it, thus aiding in approximating the deep surfaces. 2. The second method is by interrupted sutures passed the same as the suture in the lacerated perineum, that is, completely around the cavity. This suture is more difficult to employ than the former, but it is more successful. With this suture I have found no difficulty in closing at one operation an old rectal abscess of large size, which had no communication with the rectum.

In simple fistula having no cavity between the external and internal opening, I have found it possible to save incision of the sphincter by incising the sinus to the sphincter, dissecting away the false membrane up to the internal opening, and then by means of the double suture to bring the raw surfaces together. The suture is to be applied within the anus, the parts being partly extruded by the finger of an assistant hooked within the anus. The same result has been obtained by Dr. Emmet, and I believe by others. In two cases the internal opening was more than two inches above the anus, one indeed being three inches. In both cases the sinus were incised to its fullest extent, and the same form of suture employed with the best results. In my first operations I employed the single-valve speculum, but I found it by no means as useful as the finger of an assistant. When the internal opening is high up, with strong loops of ligature thread inserted into the margins of the wound at the anus, the whole track can be readily drawn down within reach of the operator.

The conclusion which I have reached from my own experience is that fistula-in-ano and old rectal abscess cavities, whether communicating with the bowel or not, can be cured by removal of the lining membrane and the application of a proper suture, in a period varying from eight to fourteen days.

I may add that I have found deep fissures of the anus readily cured by excision of the track with its cicatricial lining, and accurate closure with carbolized silk ligature, the parts being first carefully shaved and cleansed with bichloride solution, and the wound dressed with iodoform gauze. — *Medical Record*

#### INDICATIONS AND CONTRA INDICATIONS FOR THE IMMEDIATE SUTURE OF THE PERINEUM.

Proceedings of Cincinnati Acad. Med., published May 1, 1886:—The management of the perineum both during and after labor, has often been the subject of animated controversy.

This controversy has been somewhat influenced by the time in which these opinions were entertained, so that it may be said that while the older masters were mostly in favor of the so-called "let-alone" treatment, our modern authorities in a great majority are in favor of prompt artificial repair. It must not be understood, however, that the former did not recognize the necessity of closing a large chasm when caused by labor, but they did not deem it necessary to close up a rent of the perineum as it usually occurs. In a general way it may be said, then, that some of the authorities were opposed to the immediate suture of a torn perineum, no matter what its extent. These, however, were a minority. The next class admit-

ted the necessity of the immediate repair when the sphincter ani was involved, but discountenanced any operative measure as long as this muscle was intact: these formed the majority. At the present day, the great majority of obstetricians demand the immediate repair of every lacerated perineum, whether complete or incomplete, except an insignificant rupture of the fourchette, or a little beyond it, whilst a few urge the union by suture of every laceration, no matter how slight.

The opponents of the immediate suture claim:

1. That the patient is already too much exhausted from the throes of labor to undergo another, oftentimes extensive, operation immediately afterward.

2. That posture alone will suffice in effecting spontaneous union, rendering the use of sutures unnecessary; or, *per contra*—

3. That a lacerated wound, such as occurs in a perineum during labor, never heals by first intention, even after union by suture; and

4. That such union, even if it could occur, would be prevented by the constant flow of the lochial discharge, which by no contrivance can be kept from the fresh wound.

5. That a perineal laceration, as seen just after labor, seems much larger than it really is, on account of the abnormal stretching of the parts.

6. That the operation is itself a confession of carelessness or ignorance in the management of the case.

In answer to these objections, the advocates of the immediate operation claim:

1. That the patient is in a better condition to bear the operation immediately after labor than subsequently, on account of the obtunded sensibility of the genital parts.

2. That posture alone will not suffice for primary union, because the least change in position will disturb the apposition of the surfaces.

3. That although the rent in the perineum is a lacerated wound, it partakes almost of the character of an incised wound, and the surfaces will readily unite if brought together immediately after labor.

4. That in order to prevent the irritating action of the lochia on the torn surfaces, the wound ought to be closed up by suture.

5. That no matter how slight the laceration, it ought to be sutured, in order to restore the parts to their primitive condition; also because the slightest rent may endanger life by sepsis.

After examining these arguments critically, the author reaches the following conclusions:

1. A laceration of the first degree, as long as only the skin is involved, may be left to heal by postural apposition, provided there is no danger of septic infection. If there should be any danger of the latter, although the closing of the wound will not altogether prevent infection by absorp-

tion, it will at least lessen this danger, especially with antiseptic treatment.

2. A laceration of the second degree, when the fascia and muscles are torn, ought, if possible, always to be repaired immediately after the occurrence of the laceration, provided there are no complications on the part of the patient, as extensive oedema of the parts, great bruising, etc. In such an event, we cannot expect union by suture immediately; it is, therefore, necessary to wait a certain length of time, from a few hours to a few days, in order to give the parts a chance to recover their proper vitality and tonicity; or, after having pared the edges, we may introduce the sutures, and gradually tighten them as the swelling subsides. Just here I would direct attention to the tension of the suture. If it be drawn too tight, the vessels may be strangulated, and union may be thus prevented; if, on the other hand, too loose, the surfaces will recede from each other as the swelling subsides, and the stitches will serve to no purpose. Consequently great care must be exercised in the proper tension of the sutures, and if the parts do not look favorable for primary union it is better to wait a few hours, then place the patient under an anæsthetic, pare the edges, and proceed with great care.

3. Lacerations of the third degree produce such a deplorable state of the patient afterward, that every attempt should be made to repair the accident immediately. Even if we should not be wholly successful, we may be so at least partly, by converting a laceration of the third degree into one of the second degree, which is vastly more comfortable than the loss of the sphincter power of the anus. If very urgent reasons should prevent us from attending to this accident immediately after labor, we should at least select the earliest possible time to repair the accident, proceeding with all due care and skill, as in the second operation.—*Epitome.*

#### THE RELATIONS OF PUERPERAL ECLAMPSIA TO BRIGHT'S DISEASE.

Why does Bright's disease result from the pregnant state? The answer may not be altogether satisfactory, but it is certain that the condition involves the accumulation in the blood of a large amount of effete and therefore poisonous matter. We have, in fact, the same agencies operating as in many cases of Bright's disease from other causes. It is well known that acute Bright's disease is a very common sequela of scarlet fever. It is here due to the presence in the blood either of the scarlet fever poison itself, or of effete matter which is retained in consequence of the inactivity of the skin; or both of these sources of poison may

be combined. In the puerperal state we have likewise conditions favoring the accumulation of effete matters. The woman is at once the eliminator of her own excretions and those of the child, the retention of which is the essential cause of the Bright's disease. The obstruction to the circulation, due to the compression of the vessels by the gravid uterus, doubtless adds to this, but it is of itself insufficient to cause it.

There are two symptoms to which I desire to refer. The first is the blindness, and the second the convulsions. Blindness frequently develops previous to the occurrence of the convulsions. What is the cause of this loss of vision? It is known that there is a form of Bright's disease in which there are organic changes in the retina, technically termed albuminuric retinitis. These changes are most frequently associated with chronically contracted kidney. The defect of vision under such circumstances comes on slowly, but blindness, to which I now refer, comes on suddenly, and is of a very different character. It occurs suddenly, and often disappears as suddenly as it came. Such blindness evidently cannot be due to structural change in the retina. I do not know that we are sure as to its precise cause, but the most rational explanation is that which attributes it to the same cause that produces the uræmic convulsions—that is, an accumulation of urea and allied substances in the blood vessels of the brain, affecting the centre of vision, and thus blotting out for the time being the responsiveness of that centre to the stimulus to which it usually responds. The convulsions are caused in the same way. The nerve cells are irritated by the presence of these products, and the response comes in the shape of a convulsion.

We have in these facts the key to the treatment. Unquestionably, the most efficient treatment of puerperal convulsions is bloodletting, for by bloodletting we draw from the system the agent which is the most important factor in the production of uræmia. But it may be said by some that venesection is not recommended in the treatment of the convulsions of acute Bright's disease. Why then should it be used in puerperal cases, if the same essential causes prevail in both?

I believe, however, that it is a mistake not to treat the convulsions of non-puerperal Bright's disease in the same manner, and that if bleeding were more common, the results would be more satisfactory. I do not hesitate to advise you to bleed in the convulsions of acute Bright's disease. No harm can follow the removal of from eight to sixteen ounces of blood from an adult patient so that if it does no good, it does no harm. You must not, however, expect equal success, because there is still an important difference in the conditions. In the instance of renal disease accompanying the puerperal state, the termination of this state not only removes the remote cause of the

disease, but the disease itself is usually less advanced, and the chances for recovery may thus be increased.

Afterwards, or coincidently with this measure, anaesthetics are often of great service, and the patient is kept with great advantage, more or less thoroughly under the influence of chloroform or ether, in order to keep off the convulsion. This is not always necessary, for in many cases chloral answers every purpose. There is no condition in which chloral can be relied on more confidently, in connection with venesection, than in puerperal convulsions, and in the convulsions of Bright's disease. It must be given in full doses. I usually give an adult one drachm of chloral by enema. It is not worth while to give a smaller dose. The dose named may be repeated; but in the majority of cases one dose is sufficient. Chloral has the advantage over anaesthetics, in that it is possible to judge accurately of the condition of the patient. When a patient is under chloroform or ether, it is impossible to note the changes in mental condition by which almost alone we are to judge of improvement. If bloodletting and chloral are not sufficient, chloroform or ether must be resorted to. Chloroform, dangerous as it is in ordinary surgical operations, appears to be harmless in puerperal conditions.

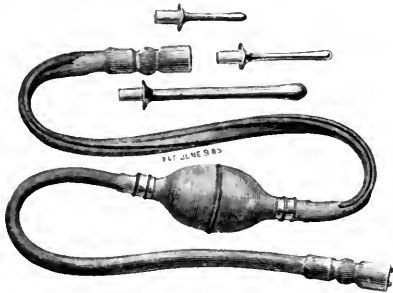
There are two other grades of complication of Bright's with pregnancy, both of which are far more dangerous than that of which we have been speaking. The first is a puerperal case with Bright's disease, where the renal affection is not the immediate result of the puerperal condition, but where it has previously existed; for although these cases occasionally get well, the mortality is much higher than in those cases of which we have been speaking.

There is a second class of cases in which, in my experience, the prognosis is invariably fatal. A girl of eighteen or twenty, with Bright's disease, who subsequently marries, is almost certain to die in her first confinement. This is an exceedingly important practical point with reference to the question of marriage of girls with Bright's disease. If a woman has had two or three children, and then acquires Bright's disease, although the condition is more dangerous than where the renal condition comes on during pregnancy, she still has a chance of getting as near well as she was before she became pregnant. The probabilities are, however, that the kidneys are left a little more damaged than they were previous to pregnancy. The renal disease is better than it was during pregnancy, but a little worse than it was before pregnancy. It is not so with the primipara who had Bright's disease before marriage. Her marriage-bell is her death-knell.—*Medical News*.

It is said that tickling the nose will stop hiccup.

## THE NEW CONTINUOUS-FLOW SYRINGE.

This new syringe, which is attracting the attention of all the leading medical men of this city, entirely obviates the intermittent action of all other pump syringes and produces a continuous stream with less exertion than other styles require. The Alpha, as the syringe is called, is perfectly simple in construction and its great advantage consists of its corrugated outlet tube, which is folded in such a manner that when filled with water it expands, and, by contracting to its original shape, keeps up the pressure while the bulb is filling. The syringe has many other advantages, such as noiseless rubber-covered sinkers and soft rubber sockets for the pipes, which require no screw-threads.



A close inspection of the cut shows a simple change in the formation of the rubber outlet tube, which completely changes the action of the ordinary instrument. This tube is made of very fine rubber, vulcanized in a corrugated or folded form, so as to contract its capacity and allow expansion. When the bulb is compressed in the usual manner, the liquid flows into and expands this tube into a temporary reservoir, and the elastic tendency of the rubber to regain its dormant shape assists the action of the syringe, and keeps up the flow while the bulb is expanding and refilling. The flow is, therefore, not only continuous, but can be either gentle or strong; or checked at once at the easy control of the user.

It is well understood that all intermittent bulb syringes act only while the liquid is being squeezed out of the bulb, the flow through the injection nozzle ceasing while the bulb is expanding. More or less air is, therefore, invariably drawn back into the syringe while the valve is seating, or oftener through a disorder of the outlet valve: fecalized fluids of the rectum are also drawn back into the tubes from the same causes, rendering an intermittent syringe offensive. It is apparent that a practical syringe constructed to produce a continuous flow, obviates many serious and oft times dangerous faults existing in the intermittent acting syringe.—*N. Y. World.*

Werner, medical officer to a circumscribed factory population of about two thousand near Narwa, on the Gulf of Finland, writes in the *St. Petersburg Medicinische Wochenschrift*, describing the satisfactory results he has obtained in diphtheria by treatment with perchloride of mercury internally, combined with ichthyol inunctions. The disease is very frequent and fatal in the locality, he having attended during the last six years ninety cases, the average mortality of which was between sixty and seventy per cent., the majority succumbing from general weakness when the local affection was passing off or after it had quite disappeared. Last year the type was peculiarly severe. In July, August, and September eleven cases occurred of which no less than nine proved fatal. From the end of September to the present time, however, during which period there have occurred seventeen cases, all of which were treated with perchloride of mercury, and many of which were very severe, there were only two fatal cases, neither of which were seen till a few hours before death.

The author's method of administration is as follows: For young children he dissolves a quarter of a grain of the perchloride in four ounces of water, for children of 6 or 7 half a grain in six ounces of water, and for adults three-quarters of a grain in eight ounces of water. This solution is given to the patients while they are awake every twenty or thirty minutes, in measured doses, so arranged that the quantities made up shall last from twenty to twenty-four hours—*i. e.*, about half a drachm in the case of young children, and a drachm in that of adults. When a good deal of sleep is obtained, larger doses are given at longer intervals. As a rule only milk is allowed as nourishment. If considerable pyrexia exists, an enema of from 10 to 30 grains of antipyrin, according to the age of the patient is given, the rectum having been previously cleared out. Externally, ichthyol is diligently rubbed in over the swollen glands three or four times a day, the fingers being wetted with water when dry to permit of the rubbing being continued for some time. For the first two days of this treatment the local affection usually undergoes no improvement, but on the third day it begins to diminish and the general condition becomes better, the appetite increasing and the children regaining their wonted spirits. In no case did the author meet with the extreme debility which was frequent in cases treated by pilocarpine even when the local affection was decreasing. As the patients approached convalescence the medicine was diminished, so that more than six bottles were never required. Complications never occurred, though three of the patients had previously had scarlatina.—*Lancet.*

CORROSIVE SUBLIMATE IN DIPHTHERIA. — Dr.

THE ORIGIN OF CANCER.—The close connection that exists between chronic inflammations and irri-

tations and cancers was long ago pointed out, and subsequent observations serve only to demonstrate more clearly what has long been obvious to nearly all professional minds. A recent writer in Volkmann's *Sammlung*, No. 257, Karl Schucharts, brings forward a series of illustrations, carefully studied, clinically and microscopically, of this connection. First of all are five cases of buccal and lingual psoriasis that have been followed by carcinoma: one of the patients had suffered from the psoriasis 30 years, another 13, another 3, and the fifth between 5 and 6 years before the carcinoma developed. Another case was one following psoriasis of the prepuce of long standing, which in its turn was supposed to be due to phimosis. A second series of cases was formed by a number of skin carcinomata following diseases of the skin. This series included chimney sweep's cancer, tar and paraffin cancer. All had this in common, that skin affections of a hyperplastic character followed chronic fouling of the cuticle by mechanical agents as well as repeated traumatism of specially disposed and exposed parts of the body, such as the arms and scrotum. To these succeeded cancerous degeneration which remained local in its action for years, but which was capable of setting up metastatic processes. Schuchardt reports six cases of this kind. The seborrhœa of old people is capable of giving rise to cancer in a similar manner. Want of cleanliness has great influence in originating these. Microscopical examination demonstrated enormous extension of the anuclear layer of the epidermis, desquamation even to the hair follicles, increased formation of salts and retention of this secretion, and especially inflammatory infiltration of the corium, and more particularly into the papillæ. To these may be added those cases of cancer that follow ulcers of the stomach, and sarcomata following blows, such as osteo-sarcomata, and such as the following, reported in the *Deutsche Med. Wochens.*, 38, 1885, by H. Lindner. A virgin, æt. 16, had a blow on the mamma. Within three weeks a sarcoma followed: within seven weeks the breast was amputated: in five months the disease recurred, and was extirpated, and within a year death took place from "marasmus." In all these cases, and such could be multiplied indefinitely, the malignant disease followed injury of some kind or other, generally chronic, but sometimes as in the latter class, acute. The question almost naturally presents itself—Is cancer, whatever its form, ever primary, *i.e.*, does it ever originate without a previous injury? Is it not in its earliest stage always an abortive and ineffectual effort at repair? The numerous facts collected seem to point to this origin, and we know of no facts that militate against such a view. Whenever cancer originates in parts open to inspection it begins in this way, and it is only when it arises in parts shut out from view that we assume that it is

itself primary. It was long thought that cancers of the stomach were primary, but microscopical examination has shown that cicatricial tissue can be demonstrated in them. The same could possibly be shown in cancers of the liver, lungs, and œsophagus, if they were subjected to the same careful scrutiny.—*Medical Press.*

ACUTE OTORRHOEA IN CHILDREN. — Under the mistaken idea that he will be compelled to buy expensive and complicated instruments, with the use of which he is unacquainted, as well as the equally erroneous notion that such treatment requires great manual dexterity and long practice, the general practitioner too often neglects the treatment of the ears of such of his little patients as suffer from otorrhœa. The results obtained by the early treatment of such cases are very satisfactory, while, as every one knows, the chronic otorrhœas are most difficult to cure. A very few applications will often stop an acute discharge, give the membrana tympani an opportunity to heal, and free the patient from the dangers and discomforts to which a neglected otitis media purulenta always exposes him. All that is needed in the way of instruments are an ordinary half-ounce rubber syringe, a little piece of wire, such as a straightened hairpin, and some absorbent cotton. Armed with these simple and inexpensive instruments, a few ounces of a one per cent. solution of carbolic acid, and a little finely powdered boracic acid, let the practitioner proceed as follows: Let him gently wash out the affected ear with the syringe and the carbolized water, warmed, using three or four syringefuls. Then let him have the nurse take the little patient to the window and allow the sunlight to fall directly into the affected ear, while he carefully and gently dries the canal with a bit of cotton wrapped around the roughened end of the hairpin probe, straightening the canal for this purpose by drawing the concha upward and backward. Then let him have the child placed on its side with the affected ear upward; and let him fill the canal nearly full of the powdered boracic acid, plugging the meatus finally with a bit of cotton. Let him repeat this process a few times at intervals of twenty-four hours, and he will be surprised to find how quickly a recent discharge will cease, and the ear regain its healthy condition. If after a week or ten days' trial he finds, as he seldom will, that the discharge does not decrease in quantity, let him throw aside the "dry treatment" and try the "wet treatment," beginning with a weak solution of nitrate of silver—say five grains to the ounce—gradually increasing the strength if the discharge does not yield. In all cases and under all circumstances, however, he should not forget that here, more than anywhere else, "cleanliness is next to godliness," and that frequent syringing with a warm antiseptic solution is the only way to keep

the stagnating and decomposing secretions from irritating the diseased mucous membrane and perpetuating the discharge—*Pacific Medical and Surgical Journal*.

**PROPOSED MODIFICATION OF PIROGOFF'S OPERATION.**—At the recent congress of Russian practitioners, Professor Tauber described and demonstrated on the dead subject an operation for removal of the foot, which he believes has several advantages over Pirogoff's amputation. Standing on the outer side of the limb, he commences an incision at the insertion of the tendo Achillis, and carries it forward just below the external malleolus to the dorsum of the foot, and then vertically downwards on the inner side in front of the heel. When the middle line of the sole is reached, the incision is carried along it backwards and prolonged upwards to the starting-point at the insertion of the tendo Achillis, a flap having thus been cut consisting of the inner side and half the sole of the heel. The joint is then opened, the external ligaments being first divided and then the internal. The astragalus is seized with the bone-forceps and removed, and the anterior part of the foot cut off by Chopart's line, nothing being left but the os calcis, the soft coverings of which on the inner aspect are untouched. The os calcis is seized with the bone-forceps and turned so that the articular surface is towards the operator. The forceps are now taken by an assistant, who holds them tightly: the operator then saws the bone longitudinally in two; the outer half, which is free, is removed, the inner half remaining attached to the flap. The ends of the tibia and fibula are then sawn off just above the malleoli. The cut surfaces of these will be found to correspond almost exactly with that of the os calcis, which is now brought into apposition with them. The advantages claimed for this operation are: 1. The posterior tibial artery itself is untouched, only its branches being divided. 2. The insertion of the tendo Achillis, as well as its bursa, are not injured. 3. Surfaces of the os calcis and of the leg bones correspond very nearly to one another.—*Lancet*.

**MEDICAL NOTES.**—Prof. Parvin regards an absolute milk diet as the very best means of treating *albuminuria of pregnancy*.

Prof. Bartholow recently practiced at the clinic the deep injection of cholormform, in two cases of *chronic sciatica*.

Prof. DaCosta prescribes the following for *lithæmia*:—

R. Liq. potass. arsenitis, . . . . . ʒj  
Tinct. ignatii amar., . . . . . ʒij  
Tinct. cinchonæ comp., q. s. ad. ʒiv. M.

Sig.—Teaspoonful after each meal.

In *acute conjunctivitis*, the following solution is a favorite one of Dr. Fox's:—

R. Acid. boric., . . . . . gr.xij  
Zinci chlorid., . . . . . gr.ijj  
Aque camph.,  
Aque destillat., . . . aa . . fʒij. M.

Sig.—Use as lotion for eyes.

Prof. Bartholow advises the following combination for *irritation of teething children* and *infantile colic*:—

R. Potass. bromid., . . . . . gr.v  
Olei anisi, . . . . . gtt. ʒ  
Misturæ asafetidae, . . . . . fʒj. M.

Sig.—Pro re nata.

Prof. Da Costa, at the Pennsylvania Hospital, showed a case of *aneurism of the arch of the aorta*, immensely benefited by iodide of potassium and rest in bed. The tumor was greatly lessened in size, and all the bad symptoms, dyspnœa, vertigo, nausea, were ameliorated.

Prof. Da Costa recently had at the clinic a protracted case of *catarrhal fever* affecting the gastro-intestinal mucous membrane, simulating typhoid. There was some abdominal tenderness, the mind was dull and heavy, but the temperature was very irregular, tongue heavily coated; nausea and vomiting a marked symptom; the bowels were constipated, and no eruption was ever found. The patient was almost cured by a regulation of diet, attention to secretions, calomel and quinine. She will now keep the bowels open with oleum ricini and take a light bitter tonic, as:—

R. Acid. phosphoricæ dil., . . . . . fʒj  
Tinct. cinchonæ comp., . . . . . fʒij  
Elixir. simpl., . . . . . fʒj. M.

Sig.—fʒj before each meal.

Prof. Bartholow prescribed for a case of *simple anemia*, which had resisted the ordinary treatment of iron, exercise and food—

R. Liq. potass. arsenit . . . . . fʒj  
Massæ ferri carb., . . . . . ʒij  
Syrup. simplic., . q. s. ad. . . fʒiv M.

Sig.—ʒj, after each meal, and take before each meal, tinct. nuc. vomica, gtt. x.

Exercise in open air about three hours after eating. An occasional purge in the form of the official pill of aloes and ferrum, or if there be flatulency, of aloes and asafetida.

At Prof. Da Costa's clinic recently was a case of *gastro-intestinal catarrh* and enlarged liver. The enlargement was due to a fatty change in the cells, and a fibroid thickening of the intercellular substance, resulting from a chronic congestion of the organ. These cases are frequently associated with gastro-intestinal catarrh. Jaundice is usu-

ally absent. The patient has been taking small doses of calomel and sodium bicarbonate, with little effect. One of the best remedies in these cases is phosphate of sodium; it keeps the upper bowel open, and acts on the liver. The patient will take one drachm, in warm water, three times per day, on an empty stomach. Counter-irritation over the liver, with tincture of iodine, also. Will live on skimmed milk, to which is added  $\frac{3}{4}$  ss of lime water to each  $\frac{3}{4}$ iv. Let her also have soups, and at times stewed oysters.—*Coll. and Clin. Record.*

**IODOFORM-COLLODION IN NEURALGIA.**—Dr. William Browning, of Brooklyn, gives his experience with this remedy for external application, together with notes on the preparation itself, and a brief study of its action. The strength usually employed is 1 part of iodoform to 15 of collodion. A half ounce is usually sufficient for any ordinary single application. Dr. Browning has found it most effective when painted on in very thick layers, which may be conveniently done with the usual camel's-hair brush. As soon as one coating becomes a little firm another is applied, and so on until it appears to have an average thickness of  $\frac{1}{2}$  mm. In the neuralgic cases a cure, when effected, was usually accomplished with one or two applications. The class of troubles found most amenable to this treatment was narrowly localised neuralgias, especially when corresponding to some particular nerve and not dependent on any demonstrable lesion. In fact, if a neuralgia, or what is thought to be one, proves intractable to this means, we should doubt its being a purely functional affection, and look carefully for some tangible cause. It has thus a certain diagnostic, as well as a therapeutic value. Several times its complete or partial failure has led to a more searching and successful examination. Even in such cases much temporary relief is often afforded. Supraorbital neuralgias, even of malarial origin, particularly if the miasmatic infection dates back some time, seem quite amenable to this treatment. Of course it is not recommended as a substitute for quinine here, but only as an adjuvant where the latter fails or acts too slowly.—(*Amer. Jour. Med. Sciences.*)

**PAPAIN, ITS USE IN THE TREATMENT OF DYSPEPSIA.**—*Chronic Stomach-Catarrhs of Children.*—I have found rapidly improve with the following prescription: R. Papain (Finkler), gr.  $\frac{1}{2}$  - gr. j; sacch. lactis, gr. j; sodii bicarb., gr. v. M. To be taken after every meal. It is also advantageous to give a drop or two of tincture of nux vomica immediately before the meal in a little water. The papain probably acts by dissolving the mucus, and thus facilitating the absorption of the food.

*In Acid Dyspepsia.* I usually order it in the following manner: R. Papain (Finkler), gr. ij;

sacch. lactis, gr. v. M. To be taken an hour after meals with the following draught: R. Sodii bicarb., gr. xv; glycerin. acid. carbolic.,  $\mathfrak{m}$ viii; spirit ammon. aromat.,  $\mathfrak{m}$ xx; aq. ad  $\frac{3}{4}$  iss. M. Fiat haustus. It appears that, taken one hour after a meal, a smaller dose of papain is required to produce the same result than if taken with the food.

*In Cases where severe gastric pain coming on shortly after eating is the prominent symptom.* I have tried the drug twelve times. Complete relief was given in ten, one case was partially relieved, and one completely failed to derive any benefit.

Apart from its internal use, papain will probably come into extensive use as a peptonizing agent, to prepare ready digested food and enemata in the way in which pancreatin and pepsin are used at present.—*Herschel in Br. Med. Jour.*,

**DISINFECTION OF INFECTED DWELLINGS.**—The following method of thoroughly disinfecting a room in which an infectious disease has existed is reported in the *Centralt. f. Chirurgie*.

The windows of the infected room having been closed tightly, 50 to 60 grammes ( $1\frac{1}{2}$  to 2 oz.) corrosive sublimate are placed on a small shovel of burning coals; after that the person leaves the room immediately and closes the door. The sublimate evaporates rapidly and exposes the room to its vapors for three or four hours. Then the door is to be opened, and, covering the nose and mouth with a piece of cloth, the person re-enters, opens the windows and closes the door again. The room having been thus ventilated for several hours, the possibly remaining vapors are to be rendered harmless by the burning of sulphur in the closed room. After repeated ventilation the room may again be occupied.—*Therap. Gaz.*

**LOCAL APPLICATIONS FOR USE IN NEURALGIAS.**—Intercostal neuralgia may be greatly relieved by daily gentle inunctions with a portion of about the bulk of a pea, of a pomade thus constituted:

Morphine chloride.	
Veratrine . . . . .	gr. iss.
Cold cream . . . . .	$\frac{3}{4}$ iv.

In lumbago, or painful contraction of the muscles of the back a liniment containing one part of tincture of capsicum in six parts of olive oil, is advantageously applicable. If its infraction be painful, it may be applied on flannel.—*Rev. de Therap.*

**CIRCUMCISION UNDER COCAINE.**—Various experiments have been made with solutions of the hydrochlorate of cocaine with the object of producing such local anaesthesia of the prepuce as would result in a painless circumcision. The results of quite a number of such efforts by myself and sev-



eral which I have witnessed in the practice of other surgeons, while greatly lessening the pain of circumcision, have not been entirely satisfactory. In the last two operations, however, which I have done by a new procedure, the first was entirely painless; in the second there was only slight sensitiveness in putting in the last few stitches.

The plan pursued was as follows: Retracting the prepuce, three or four drops of a six-per-cent solution of hydrochlorate of cocaine were injected with a fine hypodermic needle into the internal layer of the prepuce about half an inch from its attachment at the base of the glans penis. This was done so superficially that, as the needle was withdrawn, a little bleb was formed nearly half an inch in length. Waiting for half a minute, the needle was again introduced, at the opposite side of the bleb, and it slid in painlessly for another half inch in the line of the circumference of the penis. In this manner blebs were made until the cervix was completely encircled by them.

The prepuce was then drawn forward, and, by a similar procedure, another line of blebs was made to encircle the external preputial layer at the point elected for the incision. This was intended to be directly opposite the line of injection of the internal layer. The prepuce was then advanced so that the line of injection cleared the end of the glans, at which point it was compressed by a clamp, and excised without the least pain. Not the least pain was experienced in the operation except that caused by the first introduction of the needle in the internal layer, and the same in the external layer. Twenty drops of the six-per-cent solution were used in one case, and in the other twenty-five drops of a four-per-cent solution were injected.—*N. Y. Med. Jour.*

**ISCIPIENT BALDNESS.**—In commencing alopecia, VIGIER advises the use of the following formula, in which the proportions are given by weight:

Alcohol (80°)	5xx.
Camphocated alcohol.	
Rum.	
Tincture of cantharides.	
Glycerine	āā ðiv.
Essence of santal. wintergreen.	
laurel roses	āā gtt. v.
Muriate of pilocarpine	gr. viij.

The mixture is gently rubbed on the scalp once daily.—*Rev. de Therap.*

**A MODIFICATION OF FEHLING'S TEST.**—Buchner has proposed the following modification of Fehling's method for sugar. Many saccharine urines only give an opalescent yellowish-red coloration, and no red precipitate of cuprous oxide, when heated with Fehling's solution, making therefore the presence of sugar appear doubtful. In such cases, the urine is to be boiled with excess of cupric sulphate

solution (1:10). The greyish-green precipitate is to be separated, and potassic hydrate, or some Fehling's solution, to be added to the filtrate, on boiling which the red sub-oxide of copper will be deposited, if even a small proportion of sugar be present.—*London Med. Record.*

DR. LIVEZEY writes: "While wintering in Florida I met with my annual patient, a young lady of twenty-eight, from Chicago, who was sent hither three or four years ago in order to pass out into the "spirit land" comfortably, who now being troubled with poor appetite, a slight but distressing nausea, great debility, irregular menstruation, excessive cardiac action on the least exertion, etc. I ordered 1 oz. bottle of Lactopeptine of the N. Y. Pharmacal Association's manufacture and she improved at once. Soon after, she met a lady friend, who told her she ought to take Lactopeptine, stating what wonders it had done her, who was troubled "just the same way" (of course). "Why, bless me," said my patient, "that is just what my doctor prescribed for me and I am doing nicely." By the time she finished the small vial she declared she never felt better in her life, her appetite being regular and everything O. K. She has taken since Lactopeptine, Elixir, Calisaya, Iron and Bismuth, with excellent results.—*The Medical Summary.*

J. LINDSAY PORTEOUS, M.D., F.R.C.S., M.R.C.P. ED., in the April number of the *Edinburgh Med. Journal*, says:—Of late there has been a great influx of new drugs, some of great value, others of little or no use. Where a medical man has an extensive practice, consisting of rural and urban patients, he has ample opportunity of testing the effects of drugs, as the varieties of disease that come under his notice are great; and although his means of watching the actions of drugs are not so good as in hospital practice, yet a good deal can be done if he cares to take a little trouble to "take notes." The following is one which has been used for some time by my colleague (Dr. Proudfoot) and myself, and I give the results:—About eighteen months ago a friend of mine from America told me of the wonderful effects of a medicine much used in the States, called Bromidia. According to the makers it is composed of chloral hydrate, 15 gr.; potassium bromide, 15 gr.; extract of cannabis indica,  $\frac{1}{2}$  gr.; and extract of hyoscyamus  $\frac{1}{2}$  gr. I obtained some, and have ordered it regularly for over a year; and have found it excellent in the pain of rheumatism, pneumonia, and cancer; also in the sleeplessness of scarlatina and alcoholism. It has never failed me in procuring sleep, without the disagreeable dreams and after effects of opium. The dose is 5ss. to 3j. every hour till sleep is procured. I have also found it of much service in cases of tonsillitis, used as a gargle with glycerine and carbolic acid.

# THE CANADA LANCET.

**A Monthly Journal of Medical and Surgical Science  
Criticism and News**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

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## SECRET PROPRIETARY MEDICINES.

Hitherto the so-called patent medicines have been generally ignored by the profession. That we have acted wisely in simply ignoring this monstrous imposition is open to serious question. Had we been active rather than passive, our influence would not have been impotent in stemming the tide which threatens to overwhelm us, nor are we wholly guiltless of sins of commission. It is not impossible to find testimonials of the alleged virtues of many secret compounds signed by M.D.'s. We anxiously hope, in the interest of mankind, for the credit of our noble profession, and for the advance of scientific medicine, that in future no physician may be found so forgetful of his position as to endorse any secret nostrum, no matter how seductive the temptation placed before him. The manufacture and sale of proprietary medicines have become one of the prominent institutions and established industries of the civilized world. Millions are engaged directly or indirectly in imposing on suffering humanity an innumerable host and variety of alleged specifics for every ill, real or imaginary. No inconsiderable portion of the earnings of the people are engulfed in this destructive maelstrom, for which they not only receive no benefit, but often positive injury; and the sum of human misery is largely augmented by the promiscuous administration of deleterious drugs and compounds contained in these lauded nostrums.

The chief factor in promoting this giant evil is

a purchased press. It has been said that the freedom of the press is the palladium of our liberties. While this is true in a general sense, yet like all other great powers, the press is subject to abuse, and may become a great tyrant. When the financial interests of those who control it are antagonistic to the welfare of the public, its potency for harm is only equalled by its almost unlimited power. Therefore the press should be held accountable for the proper use of so great a power. That it should be required to acknowledge its responsibilities to the commonwealth, and that it should not be wholly actuated by mercenary motives, or promote fraud and imposition in its own financial interests, is obvious. The reading public have a right to demand truthful information, on this, as well as every other subject; and that the press, so potent for good, should not prostitute its high function in the worship of mammon. The common weal is its alleged and should be its prime motive and function, and only on this ground can it claim immunity from censorship. When it fails in its function or degrades its important office, public welfare demands that government should exert authority over a venal press, and restrain its cupidity. "The children of paternal government ask for bread and are given a stone."

One of the duties of government is to protect the governed from the rapacity of foreigners or subjects, from the evil results of want of knowledge and experience, and from the powerful but demoralizing influence of a suborned press. Editors as a rule, are amongst the most intelligent of the community, and cannot be excused on the plea of ignorance; although in justice, we must admit, that many of them are sadly misinformed on technical subjects, especially that of medicine. But the glaring frauds of patent medicine advertisements are so palpable, that it would be an insult to their intelligence to doubt their knowledge. Is there a newspaper in the land which does not pollute its columns in promoting this imposition? Even the so-called moral and religious periodicals are not guiltless of degradation in this respect. Who has not seen, even in the columns of the latter, advertisements criminally suggestive of "the slaughter of the innocents?"

The pulpit, that bulwark of morality, has been culpably silent on this subject in the past, and even ministers of the Gospel lend their names and

influence to promote the sale and use of these pernicious nostrums. This may have been done ignorantly, in most instances, but we have known more than one instance of reverend gentlemen furnishing a fulsome "testimonial" for some alleged panacea, in consideration of a *quid pro quo*. But possibly some excuse may be admitted, as they had evidently mistaken their calling, and the temptation to debauch their honorable profession, in which they must have been a failure, was too great, for the limited grace with which they were endued.

Should not *we*, then, who only are in a position to fully comprehend the magnitude of this ever-growing evil, exert our influence in every legitimate way against it. We are aware that our influence is handicapped by the suspicion of self-interest entertained by the laity, yet we should not permit even this to deter us from performing so obvious a duty. We are continually making strenuous exertions in the public interest against disease in many ways, and devoting our time and talents often gratuitously to hospitals, homes, asylums, infirmaries, boards of health, etc. We are searching for the causes of disease, removing or destroying them, and using every effort in promoting ventilation, good drainage, disinfection, cleanliness, etc., that sickness may be obviated or reduced to a minimum, often in direct antagonism to our own financial interest. Therefore we claim credence and confidence when our advice is given, even though it has the appearance to the lay mind of being in our own interest. We confidently believe such advice would command recognition and just acknowledgement from an intelligent public. Hence, the duty chiefly devolves upon us, to promote this much-needed reform. We should disabuse the public mind, educate opinion, expose the fallacies of this imposition, try to convince the press and the public of their duty, and by bringing the matter before the law makers, induce them to put some restrictions at least, on the indiscriminate sale of noxious drugs, and require that all proprietary medicines should have their components printed in ordinary language on the labels. We confidently trust that there is sufficient intelligence and moral stamina remaining to us, with our boasted civilization to sustain us, and to uphold any government which undertakes so great a task.

## UNPROFESSIONAL ADVERTISING.

We hope our readers will not be too much disgusted at seeing the above caption again appear in our columns, after so short a space of time. Occasional instances have come under our notice since we last wrote anything on the subject, and we let them pass. But this month we have received so many letters, backed by marked newspapers, and newspaper clippings, complaining of medical men allowing themselves to be puffed in the local press, that, distasteful as the subject is, some notice must be taken of it. The number of complaints is suggestive of an epidemic. "In the spring" a young doctor's necessities force him, apparently, to inspire notices in the papers of his city, town or village, showing forth his skill, especially in surgery. The poor physician has no blood with which to draw an admiring audience of laymen to wonder at his skill.

If we published all the letters we have received this month, our readers would have complaints *ad nauseam*. From the four points of the compass, and from intermediate points they come, some from the East being particularly glaring.

A "Card of thanks" appears in a local paper and the puffed *M.D.* makes no explanation in the following issue of the paper. "Surgical operations" described fully, in such terms that their parentage would be evident to a second year man; "Very successful operation" at a hospital; "Ovarian tumor removed," "Amputation to save life"; are headings of some of the notices sent us. Now there is not one of the medical men whose names figure so conspicuously in relation to these operations, but who could easily suppress such notices, if he so wished, and there is not one of them but knows he is transgressing the spirit of the code in even allowing them to appear, to say nothing of inspiring them. When a paper has, day after day, some item, lauding the skill of one surgeon whose name is given even to the initials, it is hardly in human nature to be sufficiently charitable to suppose that said surgeon is oblivious of the advantage he is gaining over his brethren who do not allow themselves to be noticed in the secular press, as having performed operations, which to laymen seem wonderful. There is no occasion for us to enlarge on this unsavory subject. We wrote on the subject in our January number, and thought we had point-

ed out most of the ways in which members of our profession transgress : but this month's correspondence on the subject shows that there is no limit to the ingenuity of medical minds of a certain grade to find avenues to disgraceful advertising. We have not mentioned localities, and we have been impersonal in our remarks, though some of the instances might warrant different action, and yet we are certain that what "Nathan said unto David" will come home to some of the transgressors.

### ONTARIO MEDICAL COUNCIL.

The late meeting of the Council of the College of Physicians and Surgeons of Ontario, held in Toronto, June 8th, 9th, 10th and 11th, was characterized by an unusual amount of interest, in discussion and business. There was a good representation from all parts of the Province. Dr. H. H. Wright, of Toronto, was elected President, and Dr. Henderson, of London, Vice-President ; other officers as last year. The address of the retiring President, Dr. Bergin, was listened to with much attention, and we are inclined to think, with more interest than is usually felt in such addresses. When the President of a society feels so strongly, that he openly proclaims his fears that said society has not fulfilled the end for which it was called into being ; when he raises the question as to whether it is of any service at all, he is likely to have attentive and interested listeners in those who compose such society, and who are thus, by their own chief officer, held to be useless. Every one is entitled to his own opinion as to the work which has been done by our Council since its inception, but unless we greatly err, the consensus of opinion of the medical men throughout the Province, is that the status of the profession has been vastly improved, and its interests protected by that body. It was an unhappy corporation at its birth, in that many of the members then composing it were not men to whom the profession could look with respect, either for their scientific attainments or personal qualities. But that state of affairs has passed away, and we believe that the Council as it has existed for some years past, has the respect of the profession at large. The special committee appointed to consider this address, reported straight against the cardinal points contained in

it, but owing to the absence of Dr. Bergin, the discussion which followed was not as full as it otherwise doubtless would have been. Their report was however adopted and a copy ordered to be sent to Dr. Bergin.

We imagine that too sanguine a view is held by some members of the Council, as to the action which the Home Government may take in regard to licentiates of British colleges being required to fulfil the curriculum laid down by our college. Great bodies move slowly, and before we may look for any such enactment on the part of the Home authorities, the *raison d'être* of such enactment must be clearly defined to them, a matter not of easy accomplishment, for the British mind usually considers that what is good enough for home use, is, to say the least, good enough for the colonies, whether it be pickles or medical practitioners.

The examining body appointed should meet with the approval of all concerned, as they are all good men and well known to the profession. It is to be hoped that Dr. Bray's notice, in respect to the action of the building committee, may be productive of early action in the matter of a new college building.

### THE ONTARIO MEDICAL ASSOCIATION

The last meeting of this Association, held in Toronto, June 2nd and 3rd, was in every respect a success. The number of well-known gentlemen taking part in it : the character of the papers and discussions, and the friendly spirit evinced by all, will make it remembered as a time of profit and pleasure to all who were present. Not the least pleasant feature was the presence of some American medical brethren. We are sure they were heartily welcomed, and it is to be hoped that that spirit of mutual acknowledgement of merit between members of the profession of the two countries may continue, and lead to more frequent interchange of thought at our meetings. Especially refreshing and encouraging was the presence of the veteran President of the New York State Medical Society, Dr. Moore, of Rochester. All who listened to the clear, incisive sentences, delivered with the force of full conviction of the truth of what he uttered, must have felt that they were in the presence of a mind matured by years of study and close observation. The address of the

president was a valuable one, and was well received. It is to be regretted that more opportunity was not given for discussion on the cases presented by Drs. Gibson and Yonkers. Such cavalier treatment will not encourage members to undertake the trouble and expense of bringing patients to the association meetings, for no one would be warranted in asking patients to spend their time and money in presenting themselves, were there not some hope of an elucidation of their cases by a general discussion. It is to be regretted that the report of the committee on ethics was tabled, owing to some irregularity. It will however be taken up early at the next meeting. Toronto is again chosen as the next place of meeting, which, considering its central position, and the better accommodation which may be obtained, will be of advantage to the association. Dr. Henderson's notice of motion for the appointment of a defence union committee is, we think, timely; and we trust that such steps may be taken at the next meeting as will give adequate defence to practitioners proceeded against for malpractice. The election of Dr. Richardson, as President, is a matter of congratulation to the Society. His popularity and well-known zeal in the prosecution of scientific medicine and surgery make him a most acceptable officer. We anticipate for the next meeting of the Association a greater measure of success even, than has heretofore attended its proceedings.

**MORTALITY IN THE MEDICAL PROFESSION.** Dr. William Ogden, in a report published in the *Medical Press and Circular*, shows that the longevity of members of the medical profession is in anything but a favorable condition, and that the death rate in our profession is steadily increasing. In 1880-81-82 the mortality among doctors was no less than 25.93 per 1000, while in the same years the legal profession yielded a death rate of 20.23, and clergymen a rate of 15.93 only. Nor is it with the professional classes alone that our calling compares thus unfavorably in regard to its risk to life, for even in the case of workers at some of the most unhealthy trades, *e. g.*, watchmakers, coal miners, chemists, tailors, printers, a greater immunity from death is enjoyed than can be boasted of by those who practise the healing art. "Indeed," continues the report, "to estimate the degree of danger which

medical men encounter in this respect, it is necessary to compare our calling with what we are accustomed to regard in the light of 'dangerous' occupations, such as those followed by butchers, woollen manufacturers, painters, plumbers, quarrymen, etc., and even then there is little advantage on the side of the professional laborer."

**PERSONAL.**—Mr. G. J. Romanes, M.A., F.R.S., a native of this country, has been appointed for five years, lecturer on the Philosophy of Natural History in the University of Edinburgh. Mr. Romanes has, for a number of years, devoted himself to physiological investigation, and has specially interested himself in the elucidation of the difficult problem of the evolution of the intellectual faculties. We congratulate our distinguished countryman on the high honor which he has been paid, and it is gratifying to learn from a contemporary that "There is probably no man in England equally fitted for the office."

**MANITOBA UNIVERSITY.**—The following are the names of the successful candidates at the recent examination in the above University:—

*Final for M.D.*—A. Olver, H. L. McInnis, J. R. Steep, G. E. Dixon, G. A. Lacombe, and J. Fawcett.

*Final Scholarships.*—1st. A. Oliver, \$100; 2nd, H. L. McInnis, \$60.

*C. M.*—H. L. McInnis.

*Primary Pass.*—J. P. McIntyre, R. M. Simpson, D. W. Cowan, F. Goulding, V. E. Latimer, E. A. Blakely.

*Primary Scholarships.*—1st. J. P. McIntyre, \$100; 2nd, R. M. Simpson, \$60.

**AMERICAN PUBLIC HEALTH ASSOCIATION.**—The fourteenth annual meeting of the American Public Health Association is to be held at Toronto on Oct. 5th to 8th. The following topics have been selected by the executive committee for discussion: (1) The disposal of the refuse matters of cities and towns; (2) the condition of stored water-supplies, and their relation to the public health; (3) the best methods and the apparatus necessary for the teaching of hygiene in the public schools, as well as the means for securing uniformity in such instruction; (4) recent sanitary experiences in connection with the exclusion and suppression of epidemic disease. Mr. Henry Lomb, who last year

offered prizes for the best essays on sanitary subjects, offers for the present year 1750 dollars to be awarded as prizes on the following subjects: (1) The sanitary conditions and necessities of school-houses and school life: (2) the preventable causes of disease, injury, and death in American manufactories and workshops, and the best means and appliances for preventing and avoiding them: (3) plans for dwelling-houses—(a) the cost not to exceed 800 dollars; (b) the cost not to exceed 1600 dollars.

**TREATMENT OF CHANCROIDS.**—Prof. Gross treats chancroids (*Col. and C in. Rep.*) as follows, if seen a few days after their appearance: Wipe out the sore and under the edges thoroughly with cotton, then apply with another bit of cotton carbolic acid, being careful to touch all the raw surface and to get well under the undermined edges. The pain caused by the application is but momentary, and is followed by a sensation of numbness, which prevents pain from further manipulations. Now, with a bit of cotton wrapped on a match, touch the ulcer with strong nitric acid. This will destroy whatever poison there may be left. Protect with a bit of cotton. Have the patient bathe the penis in warm alkaline water three or four times per diem. If the prepuce covers the sore, let him use a wash:—

R Cupri sulphat. . . . . gr  $\frac{1}{2}$   
 Acid. tannic., . . . . . gr. ij  
 Aquæ. . . . . f 5j. M.

Place a piece of cotton cloth between the glans and prepuce. A bubo can be aborted by injecting into it an eight per cent. solution of carbolic acid, and the use of compression. If already formed, it may be treated as the original sore.

**THE CHOLERA.**—There is no doubt that this scourge has appeared at Brindisi, and is supposed to have been brought by a P. & O. steamer. A rigorous quarantine has been imposed at all Italian ports on vessels from the Adriatic coast. It is to be hoped that such measures may be taken by the various governments as will prevent its spread westward, and that we in America may be spared, as we have been in the past few years, from so terrible a visitation.

**REMOVAL OF FOREIGN BODIES FROM THE EAR.**—Following Jonathan Hutchinson's explanation of

his method of removing foreign bodies from the ear, Dr. Gramshaw writes to the *Lancet* that he has rarely failed in this operation, by injecting into the ear hot soap suds from a five ounce syringe. He has thus removed cherry-stones, beads, slate-pencils, etc. He is of the opinion that when they are so firmly impacted as not to be removed by this method, the wire loop will fail also.

**TREATMENT OF HYDROPHOBIA BY SWEATING.**—Buisson's mode of the treatment of hydrophobia by sweating is being revived in the East. A report from Odessa goes to show that considerable reliance may be placed upon this method. A boy who showed apparently unmistakable symptoms of the disease seventeen days after being bitten, was placed in a bath, the temperature of which was rapidly raised to 42 Reaumur. He became unconscious, but was kept in the bath for one hour. He was then placed in a room at 68° and swathed in cloths. This was repeated twice a day for three days, when he appeared well and has remained so since.

**TORONTO MEDICAL SOCIETY.**—The following have been elected officers of the Toronto Medical Society for the ensuing year: President, Dr. McPhedran; 1st and 2nd Vice-Presidents, Drs. Nevitt and Machell; Recording Secretary, Dr. Peters; Corresponding Secresary, Dr. Cochrane; Treasurer, Dr. Spencer; Council, Drs. Atherton, Graham, and Reeve.

**CANADIAN MEDICAL ASSOCIATION.**—The meeting of the Canadian Medical Association will be held this year in Quebec, on the 18th and 19th of August. Arrangements will be made with the steam-boat and railway companies for reduced rates. Owing to the absence of Dr. Stewart in Germany, Dr. J. Bell is acting Secretary, and he will be pleased to hear from medical gentlemen who intend to read papers at the meeting, as early as possible, and also give any other information desired.

**ARTIFICIAL COCAINE.**—M. Merck, of Darmstadt, has succeeded in making an artificial cocaine, which is said to possess all the properties of the natural alkaloid. The price of this valuable drug having greatly decreased, it will no doubt soon be found in more general use.

**ICE IN DYSPNŒA.**—In a letter to the *Lancet*, Dr. Dawson says he has had excellent results from the application of ice to the temples and wrists in cases of acute attacks of dyspnœa in advanced phthisis. He thinks that the lowered temperature checks tissue change, with a corresponding relief to the defective lungs.

**TOOTH-ACHE.**—It is said that a solution of pilocarpine, two grains to the ounce of water, injected into the temporal region, will cure neuralgia caused by bad teeth. From an eighth to a quarter of a grain seems sufficient to check the pain in the course of an hour.

**ROSE COLD.**—It is said that a few drops of a 4 solution of cocaine will give relief in rose cold, by its astringent action upon the vessels, as well as by producing insensibility.

**M. GINJEOT** states that of all measures applied locally to boils the best results are obtained from tincture iodine. He paints the boil with a thick coating, and sometimes a single application is sufficient to cause the inflammation to subside; it is better, however, to make the application several times a day for several days. He does not recommend the early opening of boils, but if evacuation of pus be necessary antiseptics should be used.

**EDUCATORS** will be interested in the announcement that D. C. Heath & Co. have in preparation a series of Monographs on Education. Number one of these series will be a *Bibliography of Pedagogical Literature*, carefully selected and annotated by Dr. G. Stanley Hall, Professor of Psychology and Pedagogics, Johns Hopkins University.

The following have been recommended in Angina Pectoris :

R Amyli Nitritis . . . ℥ xx  
Spt. rect. . . . Fl. ʒi. M.

S. Three to five drops on sugar, every four hours.

Also

R Nitro-glycerin . . . ℥j.  
Spt. vin. rect. . . . ℥c. M.

S. One drop on sugar, every four hours.

A death certificate returned to the proper authorities by a Cincinnati physician gives the cause

of death as follows: "She died with Liver disease and New Moon."

**PROF. VIRCHOW** has recently completed his 30th year as teacher of pathology in Berlin. He has been in active practice since 1844.

A MURAL monument is to be erected to Dr. Austin Flint, in Bellevue Hospital.

## Books and Pamphlets.

**A TEXT-BOOK OF PHARMACOLOGY, THERAPEUTICS AND MATERIA MEDICA.** By T. Lauder Brunton, M.D., F.R.S., Lecturer on Materia Medica, St. Bartholomew's Hospital, London. Philadelphia: Lea Bros. & Co.

This work has been in preparation for a number of years, and was advertised from time to time as being in press, but it was purposely delayed by the author in order to enable him to experiment on certain doubtful points regarding the mode of action of drugs, and to give the results of his investigations. The work is well and carefully written, and coming from so eminent an authority, will be fully appreciated by the profession. The physiological and therapeutical action of various drugs on the animal economy have been thoroughly tested by the author, and the results are embodied in the work. Physiological and pathological questions are discussed more fully than is customary in ordinary text books. In the second part of the work on general pharmacy the author has classed together the various pharmaceutical preparations and given lists of them for reference. We commend the work to the special attention of our readers.

**A SYSTEM OF PRACTICAL MEDICINE,** by American Authors. Edited by Wm. Pepper, M.D., LL.D. Prof. of Medicine, University of Pennsylvania. Vols. III and IV. Philadelphia: Lea Bros. & Co.

The two volumes of this excellent work just published are quite equal to the standard of the two preceding ones and will be heartily welcomed by the profession. The work so far has met with a very hearty reception and is creditable alike to the authors and to American medicine. We regret that we have not sufficient space at our disposal to give it the notice that its merits demand. We can only say that those who subscribe for the work



will not be disappointed. It will not fail to meet their most sanguine anticipations.

**THE PRINCIPLES AND PRACTICE OF SURGERY.** By Frank H. Hamilton, A.M., M.D., LL.D., late Prof. of Surgery, Bellevue Medical College; Consulting Surgeon Bellevue Hospital, etc. Third Edition. New York: Wm. Wood & Co.

The original intention of the author has been strictly adhered to in the preparation of the work, viz: To supply within the compass of a single volume that kind of instruction most required in this department by students of medicine, and also to serve as a direct and complete guide to the surgeon. How faithfully and completely this has been carried out may readily be seen by a reference to the work. Each department has been treated as concisely as the circumstances would warrant; much of the literature of surgery has been omitted, and only such information supplied as a long experience in teaching and in the practice of surgery have suggested as most needed by students and practitioners. The excellent nomenclature of diseases proposed by the Royal College of Physicians of London, has been adopted by the author, the terms chosen being indicated by the letters R.C. The work is worthy of the reputation of its distinguished author, and the new edition will be heartily welcomed by the profession.

**A MANUAL OF HUMAN PHYSIOLOGY: INCLUDING HISTOLOGY AND MICROSCOPICAL ANATOMY.** By Dr. L. Landois, Professor of Physiology, University of Griefswold. Translated from the fourth German edition by William Stirling, M.D., Professor of Physiology, University of Aberdeen. Vols. I. and II: Philadelphia, P. Blakiston, Son & Co.

This work has been well received in Germany, having passed through four editions since its first appearance in 1880. It is of a most practical character, and more than any other work of the kind bridges over completely the science of Physiology and the Practice of Medicine. After a full description of the normal processes a short *résumé* of the pathological variations is given in the closing part of each section. This is a most interesting feature of the work, and one which cannot be too highly commended. The translation has been performed in a highly creditable manner by the distinguished Aberdeen professor.

**PUERPERAL CONVALESCENCE AND DISEASES OF THE PUERPERAL PERIOD.** By Joseph Kucher, M.D., formerly of Vienna Lying-in-Hospital. New York: J. H. Vail & Co.

The author has, in a moderate compass, given the views on the management of childbed, and upon the origin and treatment of puerperal diseases as accepted and practiced at the Vienna Lying-in-Hospital. The work is intended for practitioners, and consequently many points are omitted which are of no practical use, and in some cases only the leading principles of treatment are given. The chapter on puerperal fever is full of thought and will be read with much interest and profit by all engaged in midwifery practice. The author holds the view that puerperal fever is nothing else than *septic* poisoning, and has certainly made a strong case. We heartily commend the work to the profession.

**HOW WE TREAT WOUNDS TO-DAY, OR ANTISEPTIC SURGERY, FOR BEGINNERS.** By R.T. Morris, M.D., Late House Surgeon, Bellevue Hospital. New York: G. P. Putnam's Sons.

The subject matter of this work is given in a most concrete form, but is none the less attractive. It contains a very complete digest of the modern methods of treating wounds antiseptically and is worthy of careful and attentive perusal by every surgeon, whether an advocate of antiseptic surgery or not. There is much to commend in the work, and very little to which exception may be taken.

**THE SUPRA-PUBIC OR HIGH OPERATION FOR STONE OF THE BLADDER AND TUMORS.** By Sir Henry Thompson. London: J. & A. Churchill.

The modification in this operation by Prof. Peterson, of Kiel, have called attention anew to its advantages. The value of rectal distension first used by Peterson is very great, and has rendered this operation tolerably safe as regards wounding the peritoneum. Sir Henry has performed this operation eight times, six for stone and twice for tumor, and gives the results in this work for the consideration of the profession.

**THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE EAR.** By Oren D. Pomeroy, M.D., Surgeon to the Manhattan Eye and Ear Hospital. Second Edition. New York: D. Appleton & Co.

This work will be found very convenient as a work of reference on the diseases of the ear. The

present edition has been carefully revised and about thirty pages of new matter added, but no change has been made in the general scope of the work. The author has reason to feel encouraged by the treatment both the present and former editions of his work have received from the press and the profession.

**EASY LESSONS IN SANITARY SCIENCE.** By J. Wilson, M. D., U. S. Navy. Philadelphia: P. Blakiston, Son & Co.

This work is simple in style and language; brief but correct, as far as it goes, and well adapted for popular reading. It deals with land drainage, house drainage, drainage of cities, plumbing, health boards, etc. It will also be found useful to physicians, sanitary engineers and others.

**A COMPEND OF THE PRACTICE OF MEDICINE.** By D. E. Hughes, M.D., Demonstrator of Clin. Medicine, Jefferson Medical College. Philadelphia: P. Blakiston, Son & Co.

This "Physician's Edition" is based on the revision of the Quiz-Compend Edition, and also includes a very complete section on skin disease. It is merely a compend, as its title indicates, but it is very full and complete. It is well printed, handsomely bound in Morocco, with gilt edges, and will be found exceedingly convenient for ready reference.

**VENEREAL DISEASES.** By Berkeley Hill, M.D., Prof. of Surgery in Univ. Coll. London, etc. and Arthur Cooper, M.D., Surgeon to Westminster General Dispensary, etc.: Fourth Edition, revised. Philadelphia: P. Blakiston, Son & Co. Toronto: Williamson & Co.

The revised edition of this well-known work will be greeted with pleasure by its numerous friends. The size of the work has been kept down, though new matter appears in almost every chapter. The list of formulæ has been somewhat enlarged. The book will be of great value to the student, comprising, as it does, the main elementary facts relating to venereal diseases.

**QUIZ-COMPEND OF PHARMACY,** by F. E. Stewart, M.D., Ph.G., Quiz-Master in Pharmacy, Phila. Coll. of Pharmacy, etc. Philadelphia: Blakiston, Son & Co. Toronto: Williamson & Co.

This little work is very timely. Now that the various examining bodies require a knowledge of pharmacy, the want is felt of a small but compre-

hensive treatise on this important subject. The present work appears to fill the vacancy admirably. It contains a large amount of information in a comparatively small compass, and will, we are sure, be duly appreciated by students preparing for the pharmacy examination, as well as medical students.

**DISORDERS OF MENSTRUATION,** by John N. Upshur, M.D., Prof. of Materia Medica and Therapeutics in Medical College of Virginia. New York and London: G. P. Putnam's Sons. Toronto: Williamson & Co. Price \$1.25.

This is a very readable book. The author supposes an acquaintance with the anatomy of the parts, as he simply mentions their names with a running commentary on their functions. The author seems inclined to "gush" at times, which detracts from the value of the work. The printing is good, but the orthography is abominable, and sometimes the syntax, or rather the want of it, serves to obscure the sense of the passage. It will be a useful book to practitioners.

**ELECTRICITY IN MEDICINE.** By Ambrose L. Ranney, M.D., Professor of Anatomy and Physiology, New York, Post-Graduate Medical School and Hospital, etc., etc.: p.p. 147. Illustrated. New York: D. Appleton & Co. Toronto: Williamson & Co.

**CHEMICAL ARITHMETIC,** by J. Milnor Coit, Ph.D., Master in St. Paul's School, Concord, N. H. Boston: D. C. Heath & Co. Toronto: Williamson & Co.

**DISEASES OF THE KIDNEY.** By Henry Norris M.A., M.B., F.R.C.S., Surgeon to and Lecturer on Surgery at Middlesex Hospital, etc.; pp. 548, 40 engravings and 6 chromo-lithographs. Philadelphia: Lea Brothers & Co. Toronto: Hart & Co.

**MANUAL OF HYGIENE FOR SCHOOLS AND COLLEGES.** Prepared by the Provincial Board of Health. \$1.00. Toronto: William Briggs.

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### **Births, Marriages and Deaths.**

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On the 2nd inst., at Parkhill, Ont., Ida E., eldest daughter of James Taylor, Esq., Lisbon, Dakota, to Fred. H. S. Ames, M.D., Brigdon, Ont.

On the 7th inst., Edward M. Higgins, M.D., to Agnes, daughter of the late Charles Crookall, of Berlin.

# THE CANADA LANCET.

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## Original Communications.

### THE NATURE AND TREATMENT OF ACNE.

BY T. ROBINSON, M.D., LONDON, ENG.

Physician to St. John's Hospital for Diseases of the Skin.

A great deal of discussion has taken place respecting the word *acne*; some have asserted that it is a corruption of the Greek noun "*acme*," or starting point of manhood and womanhood. According to my own opinion and many others, the word is from the Greek "*acne*"; that is, bloom or efflorescence. Be this as it may, we mean now by *acne* a disease which is most usually found on the face, shoulders and chest, and which histologically is an abnormal condition of the sebaceous glands, their secretion, and the surrounding cellular tissue. We apply the noun with an adjective when we speak of *acne rosacea*, and for the purposes of description it is best to retain these names which convey a definite significance, and have been used for so many years.

I should join issue with the description of many of the varieties of *acne* which are described by all dermatologists, because many are simply the result of a fancy of the author. I allude to such compound words as *acne maculata*, *acne punctata*, *acne coneformis*, etc. Here varieties are commonly found on the same subject, and the retention of their use in our vocabulary is confusing and unscientific. I shall divide the disease into three varieties: 1. Physiological *acne*; 2. Climacteric *acne*; 3. Rose *acne*.

But before proceeding to these varieties, let us glance at the histology and physiology of the sebaceous follicles, which will be found to be intimately associated with the hair sacs. The sebaceous glands are found in every situation of the cutaneous surface, with the exception of the palms

of the hands, the soles of the feet, the last phalanges of the toes and fingers, and the glans penis. They are the only secreting glands which are found on the cutaneous surface, excepting the sweat ducts, and they have their analogue in the mucous glands in the interior of the body. The sebaceous glands are sometimes composed of two or three gland lobules which have an excretory duct, which duct rarely opens immediately upon the surface, but as a rule into the hair follicle. There is an exception in the case of the long hairs, such as we see on the skull, pubis, or axillæ: in these situations the reverse is the case, whilst in the pubescent hairs the small hair follicles open into the wide excretory duct of the gland. The gland sac is always situated in the corium, and never unites with the subcutaneous connective tissue. This is why a *molluscum contagiosum tubercle* rises so distinctly from the plane of the skin. The interior of the gland lobules is occupied by an amorphous mass of fatty matter, and the debris of numerous cells. The development of the sebaceous glands commences at the third month in man. By remembering this fact we are enabled to grasp the reason that some children are born with a hard, inelastic skin, which constitutes the disease known as *Icthyosis*, which is always congenital, and always incurable, because this gland formation is abolished by an inflammation of the skin which attacks the fetus in utero.

The function of the sebaceous glands is to give to the hairs an oleaginous secretion, and to make the skin supple, and also for the purpose of protecting it from external irritation. We see this well exemplified in coal porters and others. The constant contact of dust irritates the sebaceous follicle and their secretion is increased in quantity to such an extent that the faces of these men are quite greasy. The hair sac and the sebaceous gland form together a most ingenious contrivance, but like so many other ingenious contrivances they are put out of order by a multiplicity of causes, and it is to these that I must ask your attention. I am met on the very threshold of my subject with this difficulty: How can I separate lichen from *acne*? And let me here state that I would not separate them clinically. So intimate is the pathological state that it would be far better if we were to group both these maladies as folliculitis, or in other words inflammation of the follicles of

the skin ; but I am loth to abolish names which we have used for years.

We may get out of the difficulty in this way : By lichen we mean a papule, which consists of an imprisoned hair without an adequate secretion of sebaceous matter ; and by an acne spot we mean a condition in which the sebaceous matter is plus and the hair minus. I am aware that this is a new way to look at the maladies, but let any candid observer strip a case of lichen, and he will, in a good light, find the lichen spots to occupy the position of a hair, but he will find these spots do not occur in the ordinary acne situations. Let me be clear on this point ; lichen is usually formed on the limbs, outer aspects, sometimes on the chest and back ; or, in other words, it is found where the pubescent hairs grow abortively, but in such situations as the axilla, the pubis or whisker regions, where the hairs grow luxuriantly, we never find lichen, whilst acne is found on the nose, cheeks, forehead and chin ; or, in other words, it is found where hairs do not grow.

I must say here that I look upon the following definition of lichen as the only one which we can use. It is a papule which is always umbilicated, which has never an inflamed base, and which is always a lichen spot, it never becomes vesicular or suppurated.

Having cleared the ground as well as I am able of this difficulty, let us ask ourselves what it is which stops the mouth of a sebaceous follicle ? In the greater number of cases the over secretion of the gland is only an expression of general disorder of the whole organism, in which this secretion takes its part. Persons whose skins are thick and greasy, whose hair and nails grow fast, whose heads are scurfy, who are sleepy and stupid, who look muddy and are often the subjects of stomach derangements, are the subjects of acne. Believing that this over secretion does occur, we must follow out the effect of this bloated gland. The first stage is an elevated spot with a black head which can easily be raised from its bed, and, as we all know, if squeezed a column of sebaceous matter bulges up like a maggot, hence the name comedo (with a black head). This black head is simply due to dirt blocking up the orifice of the gland. If we place this secretion on a slide we find nothing beyond epidermic scales and oil globules. According to Gustav Simon, a six-legged parasite with a

long belly is common in these sacs. I have never seen it although I have looked for it many times. If the over secretion of the gland occurs in sebaceous follicles without an excretory duct, we have the round, pearly white bodies which are so common about the eyelids, and in the line of a cut where the ducts would be severed. These white spots are called milium, or better still, white acne.

We pass by an easy transition to true acne. The first stage of comedo is so common that it is really a normal condition of all adult skins ; but where, owing to other causes, this distended sebaceous follicle becomes inflamed, we arrive at a pathological process which will attract much of our attention and task us severely in subduing. The first process is a congestion around the sebaceous follicle, which soon runs into inflammatory action. The source of irritation is due to decomposition in the secretion, and is not a peri-follicular inflammation set up by a distended sac. You can ascertain the truth of this by smelling the contents of a large sebaceous cyst of the scalp which has become inflamed ; the surrounding tissue may be free from any sympathetic process and the contents of such a cyst are most offensive. Many suppurating sebaceous follicles of the face and elsewhere do not give rise to the formation of pus in the neighborhood of the gland, it is essentially an inflammation in the sac—this is the simple form of acne. Where the surrounding tissue becomes inflamed we have other factors at work, such as scrofula or syphilis, and these are the cases which go on for so many years and which cause such frightful disfigurement. I have under my care at the present time several cases where the history is as follows : The patients were the subjects of acne commencing in youth, they have contracted syphilis, and in addition have lived freely and drunk heavily. These cases came to me at intervals, with large bosses of inflamed tissue, especially on the forehead. This tissue as a rule suppurates, and I have in some instances let out as much as half an ounce of pus from one cyst. These are the cases which are designated acne indurata.

There is one kind of cyst which I have not yet found described, but of which I have now seen three examples. The cases which I have met with have all been women, and they have had several semi-transparent cysts on the free edges of the eyelids which looked like boiled sago. I have ex-

perienced some difficulty in puncturing these cysts because of the density of their walls. I allude to them because I have not been able to relegate them to any other malady but acne.

If we are to recognize every altered state of the sebaceous secretion as acne, which I for one would encourage, we must take many diseases into the group. In early infancy we find the fœtus covered with a layer of greasy matter, which is the sebaceous secretion that has been accumulating on the child during its intra-uterine life, and we know how much this secretion varies in quantity and consistence. Sometimes it is so tenacious that the nurse has difficulty in washing it off, in others it is absent, then the skin will found be dry and inelastic. When the hair is developing on the crown we often find the sebaceous matter accumulated on the summit in a thick, dirty cake, which gives much trouble, and in those who have an eczematous proclivity this crust begins an eczema, in fact the eczema of infants has its origin, I believe, in all cases in the irritation induced by an altered sebaceous secretion. It is too dense, and that is why cod liver oil internally and applied locally is of such signal service in these cases, it supplies fat to the secretion. Again, during cold weather, when the sebaceous matter is partially frozen like any other oily substance, we shall frequently find round patches of skin dry and scaly, especially on the face, and when this is universal we have what the laity call chapped hands and face, which in etiological phraseology is due to a too thick sebaceous secretion, which is not poured out in sufficient quantity upon the cutaneous surface. We remedy this condition by oil or glycerine, and by avoiding soap, which is an irritant in these cases, because it actually saponifies the secretion which is already too scanty, and we prevent its recurrence by warm gloves. We might reasonably include in our group Icthyosis which, as you doubtless know, is an absence of sebaceous follicles, either on the whole or a part of the cutaneous surface. When the contents of a sebaceous gland becomes so firm that its constituent elements coalesce we have horn; in point of fact the horns of the lower animals are simply off-shoots of epithelial secretion, and in our own species we find the horns of the skin are neither more nor less than dense sebaceous matter protruding from the orifice of a skin gland.

The common boils are always due to retained

secretion in a hair and sebaceous follicle. The retention may be due to special callings, such as working amongst tar, which plugs up the orifices, or we find friction producing the same effect. That is why boils are so common on the buttocks of an oarsman or a rider, or around the neck and outer aspects of the limbs, where there is most friction. Carbuncles are due to inflammation of a group of sebaceous glands occurring in those whose general health is feeble from some exhausting cause, such as old age or diabetes. The number of orifices seen oozing on a carbuncle represents the number of sebaceous glands involved in the process. The slough which comes away represents the glands itself and their contents. There is one other condition which I must allude to, that is "molluscum contagiosum." We in this country do not doubt that this is a contagious disease. On the continent they dispute the fact; but there is so much clinical testimony to support the accuracy of the contagious view, that it is impossible not to accept it, although the actual contagium has not yet been discovered. That this interesting disease is due to the invasion of a sebaceous gland by a parasite I do not doubt. The button holes on the pearl button-like little tumors, are the orifices of sebaceous glands. I might also allude to the meibomian cysts of the eyelids, to the steatoma of the skull and of other regions as maladies which are due to an abnormal state of the sebaceous glands. The varieties of balanitis and pruritis vulvæ are, many of them, simply due to a want of integrity in the sebaceous secretion.

After this very wide digression allow me to go back to what is accepted as acne, *acne vulgaris* if you like. Young men and women come before us at about the age of 13 or 14 for spots on their faces. You find these spots are situated in those parts where good hairs are not produced, such positions as the forehead, cheeks, nose. The inner surface of the external ear is a very common situation for them. These spots consist of black headed pimples, some of which may be in several degrees of inflammation, and if we strip our patients we shall find other and similar spots on the shoulders, over the sternum, and very often on the outer aspects on the arms and legs, and commonly on the buttocks, but the grouping is exaggerated on the face and shoulders. They often itch considerably when they first appear, it is this

itching which caused Mr. Hutchinson to write a paper on what he called *Prurigo Astivalis*, or *Prurigo Adolescentium*. The prominent features of this condition were a collection of abortive pustules occurring by preference on the face and upper extremities, and commencing usually at the age of puberty. Are not these tendencies exactly what we find in acne? I should have liked the words *Pruriginous acne* better. Be that as it may, we have to recognize a form of acne which does itch a great deal. I am anxious to impress this fact, because it has been disputed whether acne does ever itch.

I will now enter into the subject of those constitutional conditions which modify the progress of acne, and in the first instance I should select scrofula as the most common and pronounced of these influences. It is a peculiarity in all scrofulous manifestations that the process of inflammation is slow, and as a consequence not associated with very high constitutional disturbance. We often meet with large collections of pus in the scrofulous which are almost painless, and which are not attended by any elevation of temperature. We see this in the abscesses about lymphatic glands, and it is for this reason that we use the terms "cold abscess." Scrofula is, again, a diathesis, which as a rule is developed during the period of life when the tissues are the most active, that is to say, in the period of growth. We speak of senile scrofula, a well marked series of manifestations, which we meet with in advanced life. We owe Sir James Paget a tribute of gratitude for having been the first to isolate these conditions. Now, do we not find in patients with a skin which is thick and greasy (two conditions essential for the production of acne), and who have a scrofulous tendency, the most pronounced case of what is known as *acne tuberosa*; in such cases we shall find masses of slowly progressive inflamed tissue around the sebaceous follicles, inflammation which is edious in its progress and most obstinate to treat, and we shall find this state most commonly at that period of life when we most frequently meet with acne, that is from 14 to 25. But we shall also find later on in life some cases which are precisely the same, only they are not so general in their distribution.

Syphilis lends its characteristic colour and progress to acne, and it is most important in any case

of skin disease to remember this fact. The constitutional forms of skin disease, when crossed with syphilis, form a group which are more difficult to diagnose and treat than any other condition of the cutaneous surface. Acne is in no way an exception; frequently you will meet with an acne patient who has contracted syphilis, and in addition to the usual course of the disease, you will be baffled by a stain which is left behind when the acute local disturbance has passed away. I have a gentleman under my care at the present time who has copper-colored staining of the skin which has existed now for two years. I have some notes bearing upon the question of the influence of inherited syphilis upon the course of physiological acne, and I am disposed to believe that the influence of the disease in this form has a most important influence upon the progress of many cases of acne.

You are doubtless aware that a disease has been described as lupoid acne, or sebaceous acne, and I have seen several cases where the sebaceous follicles have been raised above the surface of the skin; these follicles have occurred in patches which have spread from their centres, and sometimes attained great size and caused much disfigurement. The persistence of this form of eruption, the manner in which it advances, and the rough follicular surface of the mass (it looks like the under surface of a nutmeg grater), stamp it at once as a new growth invading the sebaceous follicles, and being a very near relation of lupus erythematosus and acne rosacea.

But by far the majority of cases of acne are not associated with either of these diatheses. I have stated before, and I must again repeat, that three factors are essential to the production of acne:

- I. A thickness and greasiness of the skin.
- II. Activity in the sebaceous and hair follicles.
- III. An abnormal state of the glandular secretions.

The thickness and greasiness of the skin indicate that we have a large development of the sebaceous glands. We find these conditions in the greater number of cases in those with dark, sallow skins, but there are some fair haired people with thick greasy skins. Mr. Hutchinson has in his work on the *Pedigree of Disease*, a work which came as a revelation to me, a paragraph on acne as a revealing symptom, and in answer to the question, What

does acne in its various forms imply? he has these suggestive words: "We should, I think, have to reply that in the first place it denotes original and heritable peculiarity in the structure of the skin: next, that its common form in young persons usually implies greater or less disturbance of tone in connection with the sexual system." But does not acne imply still more? Do we not find in all our cases of physiological acne a laziness (if I may be allowed the expression) on the part of every excretion of the body, and an altered character in this secretion? These patients are often the subjects of indigestion, and, as they say, bilious; or, in other words, the secreting glands of the stomach are slow in action. The feebleness of the action of the liver modifies the glycogenic process. Are they not again constipated, and does not this constipation point to an altered state of the secretion from the intestinal mucous membrane? If the patients are women, we find the menstrual secretion is scanty and often much changed in character. Again, very many of these patients complain of sexual debility manifesting itself in many degrees, at times even amounting to impotence. If we take a higher flight we shall, if we know them intimately, discover that they are slow of perception, very often unusually lazy, and intolerable sleepers. And not a few from the want of activity in the excreting organs glide into gout as they become older.

Let us ask ourselves one other question: What is it that determines the introduction of acne, and what its decline? We know as a matter of universal observation that, as the sexual life of the organism approaches, the human being develops a second crop of hairs on the pubis, axillæ and limbs, and in the male sex on the cheeks, chin, and upper lip, and where this activity spends itself in the production of vigorous hair, the condition is a natural one, but where this process is spent in such situations as the cheeks, the nose, forehead and chin, where hairs are not produced we find acne spots appear. In women you will find the situations where the hair grows on the male sex very often occupied by acne, and in our sex where the facial hairs are not developed from some inherited peculiarity, acne may occur in the whisker regions. I am supposing in these cases that the skins are thick and greasy. There are happily many hundreds of human beings who cannot produce acne.

When once this acne is established it undergoes very many changes. If we watch our cases attentively we shall find any cause which depresses the vitality of the patient, causes the acne to become more pronounced. In women it is very common for a few acne spots to appear on the face during each menstrual period. In men excessive sexual indulgence has the same effect, and masturbation may produce precisely the same result. It is this latter part which has induced some to attribute (without any data I should say) all cases of acne to masturbation. The changes under the lower eyelid which we see occurring at each successive menstrual period, are due to the increased pallor of the skin of the face owing to the loss of blood, and is not in any way increased pigmentation. It disappears too quickly for such to be the case.

The association of the advent of sexual potency and acne has induced the laity to attribute these spots to chastity, and I have even heard this view supported by our own brethren. But there are manifold debilitating influences other than these which foster acne spots. The exhaustion induced by study, by late hours, by bad living, by too close confinement, by want of exercise in the fresh air; each one of these will occur to us all as being more general in their influence upon acne spots than the exhaustion induced by sexual indulgences or bad practices. It is very interesting to note in passing, how dermatologists have looked upon the causes of acne from different standpoints, those who are disposed to view the human race from a gloomy view attribute the disease to sexual excess or masturbation. Whilst the optimist attributes it to excessive chastity and over-continence.

I have one other form of acne to bring before your notice. "The acne of the climacteric period of life." I have made a separate group of these cases because they stand out in many ways as a distinct picture. This is the story. Women who had, during their age of adolescence, acne, arrive at the period of life when the menstrual function ceases, or in other words when their functions as women come to an end. And at this period of life they very often grow a crop of hair, of variable lengths on the upper lip, or cheeks, but more commonly on the chin, and we find in those who have thick follicular skin—that a crop of acne differing neither in etiological or pathological nature from the acne of youth. The common occurrence of



this form of acne on the chin has given rise to the term "chin acne," and it produces a great deal of disfigurement, and is a common condition.

I am anxious to enter on the subject of treatment with a reference to the cause, and I should like to enter my protest against the vigorous treatment of this disease generally advocated. Imagine what we do; we rub into the sebaceous follicles a strong sulphur ointment or lotion with a toothbrush sometimes, and as if to irritate a gland in a high state of inflammation, we scrub vigorously these spots with a piece of flannel and soft soap. Do we wonder that under such a line of treatment our patients pass from one consulting room to another. Such vigorous treatment may open out the orifice of the gland and let out the secretion, but sometimes it does more, it penetrates the gland, sets up inflammatory action in its interior and obliterates the gland entirely, with what result? That an area of skin lubricated by that gland becomes dry and scaly. I know of one instance of a gentleman who had simply obstructed sebaceous follicles on his nose, and he rubbed in from his own prescribing a strong sulphur ointment which set up an acute erythema of his nose, obliterating a great many of the sebaceous follicles, and for a long time he had to supply this deficiency by applying grease. I watched the case for twelve months but he made no progress towards improvement. If we think for a moment of the indications for treatment, we shall not commit this error. In the comedones, you will improve the condition of the sebaceous gland by washing the face with good soap and rain water every night. Cold water is the best because it stimulates the gland and makes it contract, and in the morning let the face be gently sponged with a very mild stimulating lotion.

The following recipe is a very excellent one :

R Hydrarg. perchloridii . . . gr. ii  
Tinct. Benzoin Co., . . . . . ʒii  
Emulsio. Amygdala, ad. . . . . ʒvi M.

And give the patient internally a medicine with the double acids in infusion of gentian, three times a day, and a claret glass of Pulma water every morning.

The selection of food is of importance. Cut out of the dietary pork and veal, and hashes and stews, pastry, and an excess of sugar. Make your patients eat whole meal bread and good butter three times

a day, and some good sound red wine, and what is most important, plenty of salt. Ask them to stimulate their skin by cold spongings; to sleep in a pure air, and oxygenate their blood by exercising several hours a day in the fresh air.

Where your patients have a family history of scrofula or other signs denoting the malady, let them have in addition to the above remedies cod liver oil.

Where there is a syphilitic tendency mercury must be used, and iodide of potassium forbidden, the latter remedy will induce acne, as will bromide.

The local condition often requires very careful management. Where a sebaceous follicle is suppurating, encourage the pus-forming process by hot applications, and as soon as you are sure it is present let it out, but make a very small opening or you leave scars.

In some acne spots the collection is in a closed follicle, a blind boil as people say, and your remedy here is to puncture where the inflammatory growth is heaped up around a sebaceous follicle.

The following solution used by Sir Erasmus Wilson is most valuable :

R Sp. vini rect. . . . . 3v  
Aeth. sulph. . . . . ʒiij

Mix and add—

Gum Mastichus . . . . . ʒxxv.

Dissolve these two.

Then add—

Iodinii. . . . . ʒij.

This must be painted on the papule, and let it remain on, which it will as a thin film, until the scale falls off. It will be necessary in some instances to abolish a sebaceous follicle which is frequently filled with pus. This can be effectually accomplished by touching the mouth with the acid nitrate of mercury of the Pharmacopœia.

I should be sorry to convey the idea that acne is easily cured; far from it. I question whether we ever cure acne in the strict sense of the word. The exciting cause runs on for some years, and you cannot check it. You may safely promise your patients that they will be better in the future, and you can always do them great good by following the lines which I have laid down for treatment. Tell your patients the acne spot is only a danger signal, hung out in a conspicuous place so that we may see it, and that this danger signal must like other such indications be attended to.

## MEDULLARY CARCINOMA OF THE LIVER AND SINGLE GALL STONE.

ALEX. FORIN, M.D., C.M., MELROSE, ONT.

On December 10th, '85, I was called to see Mrs. M. *æt.* sixty-five. Complained of pain on right side over region of liver, sensitive to slight touch, pain not increased by pressure. Upon enquiry, found that patient had had a fall on the evening of Dec. 6th but with no serious result; on turning over in bed on the morning of the 10th had experienced a sharp pain which could not be located except in right side. I gave Hydrarg. Chlor. mit. gr. vi. followed by saline, also warm applications externally. In two or three days she had recovered almost entirely, prescribed *Acidi Nitro Mur. dil. in. x.* *Tr. Nuc. Vomice m. v.* after each meal. On March 6th, '86, was again called to find a recurrence of the sharp cutting pain, described as of a cramping nature, in the liver. I then diagnosed a large gall stone in the gall bladder that had made two attempts to pass through the duct, but had fallen back into the bladder. I prescribed ether sulph. and turpentine one hour before meals continuing the former mixture after meals. The severe pain did not long remain, but left a soreness. In making examination thought I could feel nodules, and on making enquiries, found that her father had died of a cancer, and a brother died from what was called by some catarrh of stomach, although others say cancer was the cause of death. I expressed my fears of cancer to the husband but charged him to keep it from the knowledge of the patient. On March 25th, patient had a return of severe pain which persisted some days; my idea was that the gall stone had become engaged in the duct. I gave opiates, and warmth externally; considerable nausea and vomiting occurred which increased the pain. Although patient was not confined to her bed, she was gradually growing more feeble but not emaciated to any extent, being quite fleshy. On April 2nd, noticed signs of jaundice and ascribed it to impacted gall stone, and involving of substance of liver by the cancer. The bowels were kept open. The appetite was fair. Being necessitated to leave for a week or ten days, I did not see patient until April 16th, when I found her still moving around, but weaker and jaundice more marked. Put her on olive oil treatment, two ounces per diem, seem-

ed to improve and spent a portion of each day (weather permitting) driving or walking out of doors, but withal a gradual failing was perceptible. I expressed myself anxious for a consultation and Dr. W. J. Gibson, of Belleville, was called in. After a most thorough examination into the history of case and condition of patient, he agreed with my diagnosis of impacted gall stone, but finding the left lobe considerably enlarged downwards and to the left a doubt was expressed whether it was distended gall bladder or a tumor, malignant or otherwise in substance of the liver. Patient never having experienced any chill, this excluded pretty well any inflammation, and absence of fluctuation excluded abscess, although from the fleshy condition present a very satisfactory examination was not easy. Dr. G. not seeing the necessity of changing treatment I continued it with the addition of a tonic before meals, and ale and porter, but patient gradually sank. The feces were the characteristic white or blue clay color, urine highly charged with bile salts, jaundice persisting, appetite gradually failing until May 13th, when patient died.

A post-mortem examination being held I found the whole liver involved with medullary carcinoma. It was firmly adherent all around. The left lobe had reached over into the left axilla, it was adherent to stomach which had been perforated, and the result of the breaking down of the liver was that its detritus emptied into stomach giving rise to a black vomit which I could not account for ante-mortem. Drs. Gibson and Yonker, of Belleville, with myself, afterwards dissected the liver and made an incision through right lobe and found it all involved, but firmer in region of gall-bladder as if tumor had started at that point: the gall-bladder was contracted: upon opening it we found the walls about three-eighths ( $\frac{3}{8}$ ) of an inch in thickness and firmly contracted upon a single gall stone, which had partly entered the duct. The gall stone was about the size and shape of a robin's egg, weighing when dried forty three grains. Now the questions arise: How long has this gall stone been forming? Was the irritation caused by it the direct cause of the cancer? Has this cancer formed since the first attack of pain, Dec. 10th?

It seems strange that the gall stone was present and did not cause any irritation perceptible to

patient previous to 10th Dec. Excepting the attacks described above, patient had always been very healthy and active. The gall stone might have been present for some time, but had become encysted or fastened to wall of gall-bladder, and the fall of Dec. 6th may have loosened it. I would be glad to hear through the medium of your journal any suggestions as to mode of treatment.

I might here mention the advantages, and the satisfaction to both the friends and physicians, gained by holding post-mortem examinations in such cases, a thing altogether too rare; not that in this case much has been learned by us as to mode of procedure in future similar cases; but the friends have the satisfaction of knowing, that although they engaged a young practitioner, still, not much could have been done by any one, more than to alleviate the patient's sufferings. And the friends will not be told, that if they had but called Dr. W, or Dr. X, *old* and successful practitioners the patient's life would have been saved, or, if they had but tried *soot* and *cider* as was counselled by some in this case for the *jaundice*, all would have been different now.

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### Correspondence.

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#### THE COMING MEETING OF THE DOMINION MEDICAL ASSOCIATION.

To the Editor of the CANADA LANCET.

DEAR SIR,—I am glad to know that a number of the profession in Western Ontario are taking an active interest in promoting the success of the coming meeting of the Dominion Medical Association at Quebec on the eighteenth of August. Seldom does such an excellent opportunity present itself of enjoying all the advantages of the Association meetings, and at the same time having such an enjoyable trip with their families at the favorable rates which have been secured. Such a holiday trip as this promises to be could not easily be surpassed, and only six or seven days' absence will be necessary. I beg to suggest that members of the profession from Ontario who purpose going, make their arrangements to leave Toronto by the mail steamer on Monday afternoon, August 16th, at 2 o'clock. In this way Quebec will be reached on Wednesday morning, the 18th, in good time for the opening session. The social advantages which

this trip offers are apparent to every one, and I believe the medical men who purpose attending the coming meeting will have a most enjoyable time. These few lines are written with the hope that they may induce some who need a pleasant holiday trip, to take advantage of the arrangements which the secretary of the association has provided.

Yours, &c.,

July 20th, 1886.

MEDICUS.

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### Selected Articles.

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#### SLEEPLESSNESS.

One of the most common morbid conditions the physician is called upon to treat is sleeplessness. It prevents the invalid from improving; it cuts down the busy man's capacity to work; it lowers the condition of all subject to it. And certainly it is often very intractable.

Functional activity involves a full supply of arterial blood; and an anæmic condition is an essential matter for quiescence in all viscera. When we drop off to sleep the blood supply to the brain is greatly reduced; and is merely sufficient for histogenesis. During its quiescence the wear and tear of the viscus is repaired. Synchronous with this diminution of the blood supply a lethargic condition of the cerebral cells sets in probably; but about this factor we know little positively, and can only speculate.

Narcotics are agents which retard the blood flow to the brain as well as paralyze the activity of the brain cells. Some members of the group, like opium and alcohol, have a distinct preliminary stage of excitement; and by education it becomes possible to have excitement only from doses of either which would narcotize swiftly those unaccustomed to either agent. The stage of excitement is followed by lethargy. Other agents, as chloral and the bromides, if they possess any primary exciting action at all, possess it in so small a degree that it is not measurable. They are direct and simple depressants alike of the cerebral cells and the cardiac ganglia; by which latter action they lessen the blood-current flowing to the brain. Keeping this fundamental matter well in view, it becomes possible to rationally consider and reflect upon some conditions of sleeplessness, and the best measures to adopt for its relief in each case.

One good broad rule to bear in mind is this: Opium is the agent where insomnia is due to pain; chloral where it is due to a high blood pressure in the arterial system; the bromides where there is any peripheral irritation. Opium having a pro-

nounced effect upon the sensory portion of the brain as an analgesic, is the drug *par excellence* in sleeplessness due to pain, and especially osteal and periosteal pain. Whenever there is a morbid condition in tense tissues, as a syphilitic node, for instance, pain on going off to sleep is set up by that dilatation of the blood vessels of the system generally which is essential to brain depletion. The effect of the pain is to rouse the brain into wakefulness. Where such a complication exists it is well to combine the opiate with some potent depressant of the circulation, as antimony or aconite. In many cases a full dose of alcohol is sufficient for the attainment of the desired end.

Graves, of Dublin, laid down a sound and wise rule as to the administration of opium. He gave it about half an hour before the usual time of falling asleep, so that its primary stimulant effect gets over, and its secondary narcotic action is in play synchronous with the force of habit in going to sleep. By observing this rule it is often possible to secure sleep with a minimum of the drug.

In the high blood-pressure of gout and Bright's disease chloral gives the best results. In sleeplessness from excitement, too, chloral is of great service.

In peripheral irritation, as in the reproductive organs for instance, the bromides are specially indicated.

There is one matter to be ever borne in mind about narcotics, and it is this: Opium and alcohol do not produce such pronounced cerebral anæmia as follows the resort to chloral and the bromides. The brain-bloodlessness set up by chloral and the bromides lasts into the next day, and the sleepless man who takes either (in order to get some sleep) pays the penalty next day in impaired brain-capacity. They are consequently deadly agents to adopt. The alcoholic "night cap" of our forefathers was infinitely less injurious than the toxic sleep-bringing drugs of their teetotal descendants. Indeed, the preliminary stage of excitement is often the means of procuring refreshing sleep. A short anecdote will illustrate what is meant.

A friend of mine, a worthy fellow in other respects, was liable to bouts of drinking. After one of these flings his wife said to me: "My husband sleeps so badly, has miserable dreams, and wakes unrefreshed." It turned out that his medical man would only permit him some marsala. My counsel was to this effect: "Half an hour before his ordinary time of going to sleep give him a pint of the strongest bottled ale, Burton No. 1. This will make him feel comfortable to go off to sleep and he will sleep happily and awake feeling refreshed." The result was as predicted.

Sometimes tonics which fill the brain with blood in the day are followed by a corresponding anæmia of the brain at night, and thus act as narcotics.

This was well seen recently in the case of an in-patient at Victoria Park Hospital. She has been taking a mixture to soothe her stomach, with a mild narcotic pill at bedtime. One day my clinical assistant drew my attention to the fact that she was sleeping badly. My remark was: "We will not increase the dose of the narcotic, but flood her brain with blood in the day by some quinine and strychnine, as her stomach is now getting all right. And this heightened brain vascularity in the day will be followed by a corresponding reaction at night." Again the desired result was attained.

Not uncommonly a patient, often a person convalescing from some debilitating malady, will complain of feeling sleepy when going about in the day; but as soon as the head is laid upon the pillow the opposite condition of wakefulness sets in. The brain perched at the top of the organism is depleted when the patient is upright, the blood falling away into the slack and unfilled blood vessels, and so is lethargic and sleepy. When the head is laid down on the pillow the blood flows into it freely and sleepiness gives place to wakefulness. In such conditions it is well to tone up the blood vessels by the administration of digitalis along with the tonics in the day, after which the sleepiness in the day disappears; while sleep comes on naturally on lying down, especially if a high pillow be used.

A much more frequent matter is sleeplessness due to cold feet, and especially common is this with women. On inquiring it will be found that they have cold feet, and very often this coldness extends far up the lower extremities. The consequence of this arterial contraction in the vascular area of the legs is sleeplessness. The arteries and arterioles of this area do not dilate, and consequently the brain is not depleted. It is impossible to woo "Nature's sweet restorer" without remedying the vascular condition of the lower limbs. To warm the feet at the fire simply leaves them more icy cold than before, when they come into contact with the chilly bed-clothes. A warm bottle in bed is a comfort: but if the feet be rubbed (with a rough towel or bath gloves) till they glow with natural heat, then the hot bottle becomes trebly effective.

If the reader will just reflect a few moments upon the relations of cold feet to sleeplessness, he will see the force of what is said, and will also often be able to procure sleep without resort to narcotics—a matter of no little moment when their effect upon the liver and the assimilation is remembered. These unsought but unavoidable consequences of narcotics are such as to often render their exhibition most undesirable, and to induce one to turn in any direction which will do away with the necessity for resort to narcotics.

The subject has such a practical value as to make it worthy of the consideration of all men

who wish to succeed in practice; and who believe that one of the best means to that coveted end is to be able to do good to the patients who seek their aid.—Fothergill in *Med. Brief*.

### CONSANGUINITY IN MARRIAGE.

Dr. E. S. McKee, of Cincinnati, lately read a paper before the Ohio State Medical Society, in which he introduces statistics on this question, gathered from England, Scotland, and Ireland. He draws the following conclusions from his researches on the subject:

1. Like breeds like, good or bad, entirely independent of consanguinity.

2. Evil results have undoubtedly followed consanguineous marriages, but whether dependent upon consanguinity is extremely doubtful.

3. Intemperance, luxury, dissipation, sloth, and shiftlessness, as well as hygienic surroundings and innumerable other causes, among them the depraved moral state dependent on births the result of incest, should bear much of the responsibility laid at the door of consanguinity.

4. Testimony is often weakened by religious or other prejudices.

5. Data are of doubtful reliability, full of flaws and false reasoning. The noted cases are the unfortunate ones. The favorable are unknown or forgotten. It is the ill news which travels fast and far.

6. We as physicians know that there is much more illicit intercourse than is generally discovered. May not many people be related, though not aware of it. Many marriages may thus occur between relatives presumed to be non-relatives, thus again vitiating statistics.

7. Statistics show about the same proportion of deaf-mutes, idiots, and insane persons, descendants from consanguineous marriages, to the number of those unfortunates, as the number of consanguineous marriages is to the whole number of marriages. They show fertility among the consanguineous to be slightly greater than among non-consanguineous. They also show a somewhat greater frequency of retinitis pigmentosa.

8. Atavism explains fully the fact that in some instances healthy consanguineous parents beget unhealthy children. This, as is well known, occurs in most hereditary troubles. Furthermore, a less superficial examination may show this healthfulness to be only apparent.

9. Evil results in the offspring of consanguineous marriages prove that *something* was wrong. That it was the consanguinity has not been proven. It may have been one of a hundred things, and dependent upon on all of the antecedents for generations. Such results remaining absent after these marriages prove, for that case at least, that consanguinity was harmless, for it was known to

be present. Further, if consanguinity was the cause, the effect should follow where the cause is present.

10. Consanguineous marriages which bring together persons having a disease or morbid tendency in common are dangerous to the offspring. Not, however, one whit more so than the marriage of any other two persons not related, yet having an equal amount of tendency to diseases in common. Conditions present in both parents, good or bad, are simply augmented, and the result would have been the same were they not related.

11. Given, a malformation or disease firmly established, we have a tendency to breed true. Given, a defect or peculiarity in a family, race or sect, this will naturally be propagated by intermarriage, *e. g.*, color-blindness is remarkably hereditary among the Jews and Quakers. The Quakers are educated to abhor color. Those who admire color separate themselves from the sect and thus intensify the tendency in the remainder. The defect has probably crept among the Jews, and is kept up and intensified by intermarriage. The same means has also had its effect among the Quakers.

12. Certain inherited diseases—as scrofula, phthisis, and rachitis—which are ascribed to consanguineous marriages, probably in every instance could be traced back to an ancestor.

13. Man is an animal, anatomically, physiologically, and sexually. He is subject to the same laws of propagation. In-and-in breeding in animals is carried on to an extent not only not permissible in the human species on moral grounds, but also beyond the bounds of human possibility. Yet this is done by cunning breeders to improve the stock and put money into their pockets. The Jersey cattle have been bred for the last hundred and fifty years on a small island, six by eleven miles. You would not raise them for beef or oxen, yet they command a high price for their milk and butter. This was probably the recommendation of the first cattle on the island, and this quality has improved from that time to this through in-and-in breeding.

14. It would be better for the offspring were consanguineous marriages under medical supervision. Certainly no better than for all marriages to be under like supervision.

15. The half a hundred abnormalities ascribed to consanguinity, including almost all the ills that flesh is heir to—among others, whooping cough—approach the ludicrous.

16. The factors which lead to consanguineous marriages are, portions of country geographically isolated or mountainous, rendering communication with the outside world difficult; religious or political sects of an exclusive nature, and aristocratic ideas. As examples, note the percentage of consanguineous marriages in Scotland, 5.25 per cent.,

to those in England, 3 per cent. : the preponderance in Martha's Vineyard, the commune of Batz, and among the Jews and Quakers.

17. The facts do not warrant us in supposing that there is a specific degenerative effect caused *ipso facto* by consanguinity.

17. Consanguineous marriages, no other objection being present, should not be opposed on physiological grounds.

## THERAPEUTICS OF EPILEPSY.

If one may be permitted to be aphoristic on subjects like this, I would express my views regarding the therapeutics of epilepsy as follows :

I. Diet, exercise, and proper hygienic treatment, including baths, rank above all other single therapeutic measures.

If I had to choose between them and bromides even, I would select the former. On the whole, I fear that the reign of bromides has made the condition of epileptics more miserable than it was before, and has done our patients an actual harm. At the best, not more than five or ten per cent. of epileptics can be cured, while the majority are reduced by bromides to a state of physical enfeeblement and distressing mental hebetude. Besides, physicians now fly to the bromides, and trusting to them, neglect the searching inquiry into the exciting cause, or the careful direction of the patient's habits, which are so essential.

All medical experience unites in ascribing benefit to judicious regulation of diet and exercise. The only difference of late years is that we do not now believe epileptics should be starved.

Epileptics should live on plain, easy digestible diet, containing a preponderance of fat. A special meat diet, or milk diet, or farinaceous diet, is not injurious nor curative. It all depends upon the patient. A meat diet may be best if the patient is lithæmic or has a fermentative dyspepsia. A milk diet is especially useful for children and erythritic women. The meals should be small, and, in case of voracious appetite, four, five or six light meals a day should be given. No heavy meal should be taken within four hours of sleeping. Indeed, no heavy meal should ever be taken by epileptics. Special diets have often to be rigidly laid down simply as a matter of discipline, since patients will not follow any general directions. I believe that the urine and digestive functions should be carefully studied, and that thus we shall find indications for selecting the right kind of food.

II. The bromides take the second rank in the treatment of epilepsy.

All bromides act alike in this disease. If one does not cure, another will not. Occasionally changing and mixing reduces the attacks for a time, and benefits the stomach.

III. The best bromides are those of potassium, sodium, ammonium, and hydrogen (hydrobromic acid) ; possibly we may add nickel.

Bromide of potassium is the most trustworthy.

Bromide of sodium is more agreeable to the taste, less irritating to the stomach, and milder in its effects, but is eventually just as depressing as other forms.

Bromide of ammonium has a brief stimulant effect on the circulation.

Hydrobromic acid is useful in those cases in which there are indigestion and phosphaturia, and an alkali is contra-indicated. It produces acne less readily than the alkaline bromides.

IV. Bromides should be given in daily doses of 5 j, increased gradually until the attacks are suppressed, or the dose reaches 5 iv to 5 j daily. Few patients can tolerate more than this latter dose. Thorough bromidization should be always tried if necessary to stop the fits, and it may be occasionally repeated. But bromidization is sometimes injurious, even making the disease worse, and it must always be employed with caution.

V. When the fits are suppressed the bromides should be carefully reduced, but never entirely stopped for at least two years after the last fit.

VI. In most cases, and especially in nocturnal epilepsy, an extra large dose of bromide should be given at night.

VII. It is very important that bromides should be chemically pure, and their use should be continued a very long time, and that their depressing effects should be offset by tonics and all possible roborant measures.

VIII. The best non-specific adjuvants (drugs) to the bromides are potassium iodide (in syphilitic epilepsy), potassium bicarbonate (in lithæmic and rheumatic states), carbonate of ammonium, the hypophosphites, arsenic, iron, and quinine.

IX. The other chief adjuvants to the bromides are diet, exercise, a regular life, hydrotherapy, counter-irritation on the neck, and, in the line of drugs, zinc, belladonna, strychnine, valerian, and the nitrites. Combinations of bromides with the other drugs mentioned will lessen attacks when bromides alone will not.

Other drugs which sometimes help the bromides are digitalis, Cannabis indica, ergot, conium, chloral, the salts of copper, picrotoxin, and borax. None of these do any permanent good alone, and their value as adjuvants is not uniform or generally conceded.

X. The best substitute for the bromides when these do no good or do harm, are belladonna, zinc, strychnine, glonoïn, borax, and alteratives.

XI. Bromides stop the fits in from five to ten per cent. of cases, oftener if given early in the disease, if given to young children, and if given in cases that develop after twenty-one.

Bromides lessen the fits in from eighty to eighty-five per cent. of cases.

Bromides do no good, or do actual harm, as regards frequency of attacks, in from five to ten per cent. of cases. Bromides do no actual good to the patient in a much larger proportion of cases.

XII. To prevent bromide acne, arsenic, calcium sulphide, baths, and diuretics are the best measures, or hydrobromic acid may be used.

To prevent bromidization, adopt all possible roborant measures: use salt-water baths and regular physical exercise, give black coffee, caffeine, cocaine, mineral acids, strychnine, bitter tonics, cod-liver oil, or give large doses of the bromides every three days only.

In all cases dilute the bromide, preferably with carbonic acid water on Vichy, in the proportion of six ounces of water to a scruple of the drug.

The continuous administration of an alkaline bromide in an alkaline water sometimes effects the bladder, and then the bromides can be given dissolved in hydrobromic acid.

XIII. The remedies that are especially useful in *petit mal* are, after the bromides, belladonna, glonoin (?), *Cannabis indica* (?), cod-liver oil, ergot (?), counter-irritation at the back of the neck, and cold spinal douches.

XIV. For epilepsy in children, besides the bromides it is advisable to employ a milk diet, rest, and oxide of zinc. Belladonna, if tried, should be given cautiously.

XV. For adults and chronic cases, use the bromides, belladonna, iodide of potassium, and ammoniated sulphate of copper. Oxide of zinc is here of less value.

XVI. For nocturnal epilepsy, increase the dose of bromide at night, and add chloral or digitalis. Give also, if needed, strychnine. Raising the head of the bed or making the patient sleep in a chair at night, are measures to be tried.

XVII. For hysterical and erythritic cases, with or in place of bromides, give a diet of vegetables. Try turpentine, valerian, or zinc. Belladonna is usually contra-indicated.

XVIII. Counter-irritation by means of blisters, issues, and setons at the back of the neck, is a useful adjunct to treatment, especially in *petit mal* and in cases with mental derangement.

XIX. For the status epilepticus, give large enemata of chloral, and use emetics and purges. Venesection is often efficacious, morphine is dangerous, chloroform is only palliative, and nitrite of amyl is of little value.

XX. To prevent impending attacks, the best remedy is nitrite of amyl, which may be carried in a phial filled with cotton. Inhalation of chloroform or ammonia, the internal administration of ammonia, spirits of lavender, or alcohol, a sternutatory, and pressure on the carotids—all are measures which sometimes stop the attack.

XXI. Alterative and habit-breaking drugs, such as mercury, iodide of potassium, arsenic, antimony, are useful in epilepsy.

XXII. No surgical measures upon ovaries, uterus, testicles, cranium, or elsewhere will cure an established long-standing epilepsy, except in rare cases. Such operations, if done, should be undertaken early, before the patient has had an excessive number of fits.—Dr. Dana, in *N. Y. Med. Jour.*

LUNG TEST IN INFANTICIDE.—Sommer, of Dorpat (*Viertelj. f. gericht. Med.*) furnishes a contribution to the controversy which has been carried on for over three years, as to the effect of Schultze's method of artificial respiration on the reliability of the hydrostatic lung test in cases of infanticide. It will be remembered that, in 1883, Runge called attention to the fact that Schultze's method of swinging the child was not only efficient in causing apparently dead newborn children to respire, but was also capable of more or less distending the lungs of really stillborn children; and he therefore urged the importance of bearing this in mind in cases of alleged infanticide. The possibility of such inflation being produced in the dead child by Schultze's method—whereas it is well known that all previous methods of artificial respiration have failed to produce such an effect—is, apart from actual direct experimentation on the dead, rendered more likely, since Torggler has recently shown, by a series of careful experiments (*Wien. Medic. Bl.*, 1885, Nos. 8 10), that Schultze's method is of all methods of artificial respiration the most certain in restoring newborn children. Direct experiment on the dead is attended with difficulty, since it is in the great majority of cases difficult to prove that the inflation of the lung was not produced by some unobserved inspiration during or after the birth of the child. Hence so eminent an authority, as Hofmann, of Vienna, maintains that the air found by Runge and others in the lungs of stillborn children, after manipulation by Schultze's method, has really entered the lungs before, and is the result of aborted natural respiration. He himself has made the experiment with absolutely stillborn children, but found no air in the lungs. It is alleged, however, by Runge, and those who agree with him, that the children with which Hofmann made his experiments were not full-grown fetuses, and that immature fetuses (eight months and under) are known not to have their lungs affected by Schultze's method. This allegation appears to be borne out by a reference to the children operated on by Hofmann.

Prof. Schauta has written a paper in which he supports Runge; while, in a still more recent paper, Dr. Nobiling takes the side of Hofmann. Sommer, who is Runge's assistant, now takes up



the pen in defence of his chief, and produces the protocols of two cases in Runge's clinic which appear to place it beyond doubt that Schultz's method is capable of more or less inflating the lungs of stillborn children so as to simulate respiration. Both children—one of which was a twin—were mature, or nearly mature, and both were ascertained by auscultation, and otherwise, to have been alive to within a short time of the completion of their delivery, previous to which they were with great certainty ascertained to have died, and before there was any possibility of their having breathed—in one case before the membranes had ruptured. In each case the child was swung thirty times, according to Schultz's method. On opening the chest the lungs in both children were found to be distended and mottled; and although they did not swim in water when attached to the thymus and the heart, they floated readily by themselves, as did also the greater number of small pieces into which the lungs were divided. The only uninflated portions were toward the base of the lungs. This confirmation of Runge's results is becoming the more important, since nurses are now being trained in several parts of the world in the practice of Schultz's method of artificial respiration. It adds a new difficulty to the many difficulties attending the medico-legal investigations of cases of alleged infanticide.

**TEA-DRINKERS' DISEASES.**—It is not a little curious that the diseases arising from the wrong use of tea should be met with in greater frequency in countries foreign to its growth. It might have been supposed that where production went on there would be found those evils that attend the consumption of tea in their greatest extent; but such does not appear to be the case. The diseases due to tea are well known to doctors, but the public seem to be strangely indifferent to the teachings of their medical advisers in these matters. Recently in France M. Eloy has reminded medical men how vast is the number of diseases owing an allegiance to the dominion of Queen Tea. The list of headings in M. Eloy's paper is well calculated to arouse attention, and, we hope, to lead to some abatement of this widespread disorder. America and England are the two countries that are afflicted most with the maladies arising from the excessive consumption of tea. Individuals may suffer in a variety of ways. It is customary to speak of acute, subacute, and chronic "theism"—a form that has no connexion with theological matters. It is possible to be a "theic" by profession or a "theic" by passion. The predominance of nervous symptoms is a characteristic of theism; general excitation of the functions of the nervous system may be observed; or the weakness may be noted more especially in the brain as distinguished from the

spinal cord. Perversion of the sense of hearing is not at all an uncommon symptom—patients hearing voices that have no real or objective existence. The irritability that overtakes women so frequently may sometimes be clearly traced to an excessive indulgence in afternoon tea. It is a mistake to suppose that it is the poor sempstress who is the chief sufferer from theism. No doubt the tannin which tea that has been standing long contains does a great amount of mischief, but the derangement that it causes hardly belongs to that class of diseases with which we are at present concerned. Rather does theism belong to that genus of disease in which morphinism, caffeism, and vanillism are found. The habit of tea-drinking is one that grows on its victims like the similar ones of opium or alcohol. Taken in strict moderation, and with due precautions in the mode of preparation, tea is, like alcohol, a valuable stimulant; in its abuse there is also a certain analogy. There is hardly a morbid symptom which may not be traceable to tea as its cause. This is a fact that general practitioners often use to their own satisfaction and to their patient's advantage, if it happen to be that kind of patient who does not object to make some sacrifice in order to be rid of troubles.—*Lancet*.

**MEDICAL NOTES.**—Prof. Bartholow gives hydrocyanic acid for two or three days, followed by calomel, in the treatment of the *round worm*.

For *myalgia*, Prof. Da Costa prescribed the following lotion:—

R. Chloral., ℥j  
Lin. saponis comp., f℥ij M.

Prof. Bartholow treated a case of *intercostal neuralgia* by the local application of a cone of chloral and menthol, moulded by the aid of spermaceti.

*Nasal polypi* can sometimes be destroyed by—

R. Acid carbol., ℥iij  
Aque, f℥ij M.

Sig.—Inject a few drops into substance of polypos. (Sajous.)

Prof. Parvin treated a case of *choria* as follows:

R. Liq. potas. arsenitis, gtt. ij

Sig.—Take at meals.

Also—

R. Hyoseyamin. sulph., gr. 2  $\frac{1}{10}$   
Sodii brom., gr. v M.

Sig.—To be taken in solution ter die.

Prof. Da Costa treated *furunculi* with the following, with good results:—

R. Liq. potas., āā f℥ss  
Glycerini, āā f℥ss  
Aque, f℥ij M.

Sig.—Use as lotion to soften old crusts.

R. Hydrarg. chlor. corros., gr. iv  
Aqua, ʒi M.

Sig.—Use as wash, twice daily, to parts affected.

Dr. Jurist recommends the following in various conditions of the *throat* requiring a gargle :—

R. Tinct. guaiac. comp.,  
Tinct. cinchon. comp., āā fʒij  
Potas. chlor., fʒj  
Mel dep., fʒi  
Aqua, q. s ad fʒiij

Sig.—As a gargle.

Prof. Bartholow had at his clinic a patient with *hepatic colic*, who was not jaundiced. The stone may be of such a size that suffering is produced by its passage through the cystic duct, while it passes without pain through the common duct, and without obstruction; therefore jaundice is not produced. To keep the bile alkaline and so prevent the further formation of gall stones, give persistently sodium phosphate.

From a lecture recently given by Dr. Hearn, the following was taken regarding treatment of *gonorrhoea* :—

For first stages, a mild diet; avoid excesses, especially of drink; locally, hot-water baths for penis, also hot-water injections, together with the antimonial saline mixture, or—

R. Potas. citrat., gr. xx  
Sodii bromid., gr. xl M.

Sig.—Ter die.

In second stage, resort to copaliba, cubebs, and especially was oil of sandal wood recommended. Copaliba could be given in a mixture of acacia syrup and water, together with citrate of potassium, or in syr. sarsaparillæ with cubebs.

In third stage, use one of the following as injections :—

R. Plumbi acet., gr. ij —  
Zinci sulph., gr. j  
Aqua, fʒj M.

Sig.—As injection.

R. Hydrarg. chlor. corros., gr. j  
Liq. calcis, fʒj  
Aqua, fʒxij M.

Sig.—As injection.

If discharge persists, use steel bougies, three times a week. — *Col. & Clin. Record*.

**WHITE SWELLING OF THE KNEE.**—In a paper read before the Med. Soc. of New York, Dr. Judson advocated the doctrine that it was essentially an inflammatory affection, and that an inflamed organ or tissue demanded arrest of function in the treatment, if the best results were to be obtained: that inflammatory conditions were relieved or removed by arrest of function, wherever it could be secured.

The essential feature of the treatment for diseases of joints should, therefore, be fixation.

Prolonged fixation with disuse of a joint would not produce ankylosis, provided the joint itself was free from disease. Of course, it would be followed by stiffness, but that would yield by persistent passive movements, and was entirely different from ankylosis. The ankylosis which followed joint diseases, and was caused by the final products of inflammation, was best prevented by reducing or removing the inflammation, and to do this most effectually arrest of function was essential.

Fixation applied to a joint would, so far as the joint was free from disease, be powerless to add to the ultimate degree of ankylosis, and, so far as the joint was diseased, it would diminish the ultimate ankylosis by arresting the inflammation and preventing an excess of its products.

On these premises thorough fixation was required in the treatment of articular osteitis. Dr. Judson thought it was impossible to establish the statement that motion was required to prevent inflammation.

In the treatment of joint disease, in the lower extremities particularly, another important function must be considered, namely, that of supporting weight and concussion. Protection of the articular surfaces from pressure and concussion was very important, and to accomplish this most certainly, the best method was to convert the affected limb into a pendent member, putting it into very much the same condition, in this respect, as were the upper extremities.

When these indications had been thoroughly met, Dr. Judson believed that the patient had received the highest degree of assistance which surgery could afford.—*Építome*.

**THE THIRD CORPUSCLE OR BLOOD-PLAQUE.**—Dr. William Osler, of Philadelphia (*Cartwright Lecture*, published April 3, 1886), defines what is called the third blood corpuscle or blood-plaque as a colorless, protoplasmic disc, constant in mammalian blood, measuring from 1.5 to 3.5 micromillimetres. The number per cubic millimetre in the blood of a healthy adult is about 250,000, but their number varies greatly at different periods of life and with varying conditions of health and disease. The ratio to the red is about 1 to 18 or 20. They are delicate elements, and, like the red corpuscles, tend, on the withdrawal of the blood, to adhere to one another, when they form the irregular granular clumps which have long been known as Schultz's granular masses.

The plaque is colorless, with a uniform grayish-white appearance, homogeneous or finely granular, and presents no differentiation in the delicate protoplasm of which it is composed. So far as his observation goes, it is always colorless.

The shape of the normal plaque, as seen in the

vessels, is a circular disk with smooth, well-defined margin. When slightly tilted it has naturally an ovoid appearance, and when seen in profile is a narrow, straight rod or staff. Whether they are flat discs, or biconcave, like red corpuscles, is really not easy to determine.

In the unaltered condition no nucleus can be seen, but in the fluids used to conserve them the appearance is in the form of a collection of distinct granules, which may look like a nucleus. This will sometimes, in dried preparations, stain a deeper color in the hæmatoxylin than the remainder of the plaque, and it is regarded by Hayem as a nucleus.

A majority of observers regard the plaques as independent elements in the blood: others agree with Hayem that they are young red corpuscles—hæmatoblasts.—*The Epitome*.

**THE NATURE AND TREATMENT OF PNEUMONIA.**—Dr. Stewart Lockie (*Edin. Med. Jour.*) thinks that the ordinary form of pneumonia is of infective nature, but he does not deny that there may be other forms, as, for instance, gouty pneumonia. Of the infective diseases, erysipelas is the one to which pneumonia has the closest alliance. Both usually occur sporadically, but occasionally in an epidemic form; both have a somewhat similar, more or less definite, duration: both are apt to attack the same individual repeatedly, occasionally many times in succession: both are occasionally complicated with meningitis. Leyden and Koch assert that the micro-organism of pneumonia closely resembles that of erysipelas.

In the treatment of the disease, the writer is opposed to all lowering measures. It may be that cases occur in which excessive dyspnoea and engorgement of the right heart call for moderate blood-letting, but he has never seen a case where he has been tempted to resort to it. The patient should be placed in a pure atmosphere with an equable temperature and supplied with moderate nourishment, not too much, lest we overtax the kidneys, which are probably the main agents in eliminating the poison. For the relief of pain, opium in the form of Dover's powder or by hypodermic injections of morphine, unless there is organic disease of the kidneys, when opiates had better be avoided. The writer advocates the use of hot poultices, and his habit is to give carbonate of ammonia from the start, although he admits that in the early part of the disease its use is empirical, later it is useful in supporting a failing heart. Where the temperature exceeds 103°, he gives quinine, in commencing doses of ten grains at night and five in the morning, increasing the doses if these do not control the temperature. If the stomach rebels, give it hypodermically or per rectum. The writer has seen such good results from quinine that he is inclined to agree with Dr.

Burney Yeo in thinking that it is not given often enough, and is inclined in future cases to use it systematically from the first. Failing circulation calls for alcohol and digitalis.

**MAMMARY FUNCTIONS OF THE SKIN IN LYING-IN WOMEN.**—The breast may be regarded as a highly specialized sebaceous gland, or at least, as a highly specialized cutaneous gland. It may have developed out of the indefinite blastema of the epiblast, either directly or through the intermediary stage of a sebaceous gland. The distinction made by Dr. Creighton at the discussion of Dr. Champney's paper, at the Royal Medical and Chirurgical Society, will, in view of deeper embryological considerations, appear to be of not great importance. For, it is plain that the glandular structures to which he referred must have originated from epiblastic germs, as the sebaceous, sweat, and mammary glands have also done. That a sebaceous gland is also a miniature breast must be regarded as theoretically proven from a chemical stand-point. Milk is a chemical compound in certain proportions of albumen, fat, and sugar, and analysis of sebaceous matter also yields fat and a small proportion of proteid and carbohydrate. Dr. Champney's most careful and detailed description of the "axillary lumps" forms the result of an equally sedulous research, which, so far as is known, is unprecedented, and therefore original in the true sense of the word. The lumps that he described as situate in the axilla may for all practical purposes be regarded as mammae. Their evolution follows step by step that of the mammary glands in parturient women, and there are some grounds for believing that they may be the seat of similar pathological affections. Further, Dr. John Williams bore testimony to the effect that, like the breast, the axillary lumps may show changes during menstruation.—*London Lancet*.

**HEADACHE CURED BY SALICYLATE OF SODIUM.**—The action of drugs in megrim and gout is remarkably similar. Troussseau and others have used colchicum with benefit in megrim, and other observers have remarked on the similar curative effects that certain purgatives, as calomel, have in both gout and megrim: and, again, others have used pot. iod. with considerable success; but the great value of salicylate of sodium in some of these headaches is more remarkable still: it seems to me to be most certainly curative and not merely palliative, as it removes the concomitant gastrointestinal troubles along with the headache. Thus, a dose of brom. pot. and sp. ammon. aromat. will sometimes remove a slight headache, but it will probably return: with salicylate treatment it is quite a different matter, the headache is gone once and for all, and shows no sign of return for a considerable period: its action in this respect is very

similar to that of calomel, and, like calomel, it seems to free the secretions of the mouth, and, at the same time, slightly relaxes the bowels.

The dose of salicylate I use is two to three grains every quarter or half hour for three or four doses or more, as recommended by Dr. Brunton, and begun when the headache first comes on: this is sufficient. A patient might carry dr. i of the powder in his pocket and take a little when a headache threatens, and he would soon learn to judge the proper dose by sight.

And as to diet, from which meat, cheese, beer, wine, and spirits are absent, I will only say that experience has more and more convinced me of its value in such cases.—*London Practitioner*.

**OPPOSITION TO THEORIES OF MICROBIAL INFECTION.**—At the meeting of the Alabama State Medical Association, held in Anniston on the sixteenth of last month, Dr. B. J. Baldwin reported twenty-five successive extractions of cataract without a failure. In the course of his remarks on these cases he said that he had used no disinfectants, and did not consider them necessary outside of hospital walls. He also said that he had been very much interested, and rather amused, at the scrupulous disinfection of the eyelids and eyeballs, and the hysterical anxiety to have even both eyes deluged in solutions of bichloride of mercury and boracic acid preceding every operation. He did not wish to be understood as denying that disinfection might often do good in the poisoned wards of old hospitals, but he did assert that anything more than cleanliness, in the extraction of cataract, outside of the hospital, was unnecessary and sometimes even harmful.

Then speaking of antiseptics in general, he continued: "I do not believe, furthermore, that there exists in all space a deadly venom ready and anxious to leap into every wound, to hasten the part on to destruction. There is bread that hath no leaven, and air as well without germs. Many of my friends may think this unpardonable heterodoxy, and my German confrères will no doubt stand aghast, but I am confident that they will sooner or later come to the conclusion that the world is not so soaked in bacteria as they at present imagine. It is difficult to conceive that an all wise and ever-merciful Maker would have so filled His universe with these infinitesimal death-worms, and that fresh air and sunshine are simply the danger-house from which they may be signalled when an opportunity to attack a wound arises. Cleanliness embraces all of the virtues of disinfection, and it is the sole element of its success."

These are certainly pretty strong words, but judging from the indications we see about us we may expect now to hear declarations of this sort from many different quarters. The opponents of bacteriological theories are beginning to assert

themselves with much more vehemence than they dared to use a short time ago, and, gaining courage as they proceed, they will give the advocates of the new doctrines a task in defending their theories. We are not sorry to see the signs of the approaching struggle, for, true or false, the microbial theories have, we think, been too readily accepted by the mass of the profession upon the authority of a few learned investigators. All the arguments pro and con have not yet been set forth as clearly as they might be; and an animated discussion will do good in establishing the truth or falsity of these latest theories of disease. But the conservatives must remember that talk is not always argument. The bacteriologists allege facts and experimental research as the basis upon which their theories rest, and their opponents must bring forward equally strong facts if they wish to gain the approval of the profession for their cause.—*Med. Record*.

**SOME FALLACIES IN REGARD TO DIET.**—1. That there is any nutriment in beef-tea made from extracts. There is none whatever. 2. That gelatine is nutritious. It will not keep a cat alive. Beef-tea and gelatine, however possesses a certain reparative power, we know not what. 3. That an egg is equal to a pound of meat, and that every sick person can eat them. Many, especially those of nervous or bilious temperament, cannot eat them; and to such, eggs are injurious. 4. That because milk is an important article of food, it must be forced upon a patient. Food that a person cannot endure will not cure. 5. That arrow-root is nutritious. It is simply starch and water, useful as a restorative, quickly prepared. 6. That cheese is injurious in all cases. It is, as a rule, contra-indicated, being usually indigestible; but it is concentrated nutriment, and a waste-repairer, and often craved. 7. That the cravings of a patient are whims, and should be denied. The stomach often needs, craves for, and digests articles not laid down in any dietary. Such are, for example, fruit, pickles, jams, cake, ham, or bacon, with fat, cheese, butter, and milk. 8. That an inflexible diet may be marked out, which shall apply to every case. Choice of a given list of articles allowable in a given case must be decided by the opinion of the stomach. The stomach is right, and theory wrong, and the judgment admits no appeal. A diet which would keep a healthy man healthy might kill a sick man; and a diet sufficient to sustain a sick man would not keep a well man alive. Increased quantity of food, especially of liquids, does not mean increased nutriment; rather decrease, since the digestion is overtaxed and weakened. Strive to give the food in as concentrated a form as possible. Consult the patient's stomach in preference to his cravings; and if the stomach rejects a certain article, do not force it.—*Technics*.

**A PECULIAR SPUTUM IN HYSTERIA.**—Dr. E. Wagner has called attention to a peculiar sputum often observed by him in hysterical patients, the appearance of which might readily excite the suspicion that a phthisical affection is to be dealt with. But in fact it has been observed invariably as coming from subjects (always hysterical) who show no symptomatology by which tuberculosis of the lungs may be confirmed. The sputum is, of course, free from bacilli, is of a hemorrhagic nature, mostly red, but of a lighter red than ordinary bloody sputum, and not in any way resembling ordinary rusty-colored sputum. When examined in a glass it appears like a reddish or brownish-red pulp, in which numerous small gray particles cover the bottom. This sediment is so characteristic that it is easy to make the diagnosis with the naked eye. In one case the sputum for several days, in color and consistence, resembled a raspberry jelly, so that he suspected the development of a sarcoma or carcinoma in the bronchial tubes, under which circumstances it is usual to see this character of sputum. Under the quantities of small red blood-corpuscles, and along with them, frequently, numerous white blood-corpuscles, pavement epithelium, and cocci. Alveolar epithelia from the lungs were not discovered. Sometimes mucous pockets are found embracing pus cells. In every case, upon failure to find signs of disease of the lung or larynx, the author believes he has a right to conclude that the bloody coloring proceeds from small bleeding vessels, that the colorless part of the sputum is a pathological secretion of the mucous membrane, and that probably it all originates in the buccal cavity. The writer reports four cases in which he had observed this sputum for a considerable length of time; in one of which, however, bacilli at length appeared. In all cases an investigation for bacilli is of prime importance with a view to differential diagnosis.—*Deutsche Med. Zeitung*.

**BISMUTH SUBNITRATE IN FETID PERSPIRATION OF THE FEET.**—Vieusse recommends the subnitrate of bismuth in the treatment of fetid perspiration of the feet, and concludes as follows:—(1) Profuse perspiration of the feet, whether accompanied by pain or fetidity, is easily cured by the application with slight friction of subnitrate of bismuth upon the diseased parts. (2) In opposition to the opinion generally held, according to which the suppression of exaggerated perspiration may produce numerous accidents of metastasis, observation shows that the cure of this affection has not been followed by unfavourable results, and that if these are observed they should be attributed to other methods of treatment hitherto employed. (3) In the cure of this disease, subnitrate of bismuth appears to exercise a purely local action, rendering the superficial cuticular structures firmer and more resistant. The remedy, perhaps, exerts an action

also upon the sudoriparous glands and sebaceous follicles, changing the quality and quantity of their products, and possibly as a result of the changes produced in the part with which it comes in relation, modifies more or less profoundly the capillary circulation. (4) In certain cases the remedy suppresses only temporarily the profuse perspiration of the feet, but causes the fetid odour, as well as the pain, which is the consequence of the exaggerated secretion, to disappear permanently. (*Rivista Internazionale di Medicina e Chirurgia*.)

A YOUNG doctor was recently purchasing a stock of drugs from one of our retail druggists, "I shall want a good supply of calomel," said he, "give me a pound—the dose is a drachm, you know." Posological views of this kind are by no means uncommon, and well it is that the druggist generally bars the way to their being fully carried into practice. Experience, not always purchased at the expense of the young practitioner, and not unfrequently to the benefit of the undertaker, generally rectifies these errors, but this is not always the case. Peculiar opinions as to chemical, pharmal and therapeutical matters are sometimes held by practitioners of more mature practice. One of the best instances we have ever seen is furnished by a correspondent not a hundred miles from—Ont., who sends the original of a prescription received by him last month. It reads as follows:

“R Hydrarg. Ch Cor . . . . . 5ij.  
Rhei pl. . . . . 5ij.  
Mur. Ferri. . . . . 3j.

Into four powders: one taken last thing bed time, one first in the morning until all are taken.”

It is hard on the poor druggist to set aside all his notions as to the nature and doses of the ingredients ordered, but to require the unfortunate patient, who has already taken his quietus at bed time, to recommence the powders, "one first in the morning until all are taken," making, in fact, a regular breakfast of it is altogether unreasonable and unnecessarily unkind.—*Canadian Pharm. Journ.*

**HEADACHE IN SCHOOL CHILDREN.**—Prof. N. J. Bystroff has examined seven thousand four hundred and seventy-eight boys and girls in the St. Petersburg schools, during the last five years, and found headache in eight hundred and sixty-eight; that is, 11.6 per cent. He states that the percentage of headache increases almost in a direct progression with the age of the children, as well as with the number of hours occupied by them for mental labor: thus, while headache occurred in only five per cent. of the children aged eight, it attacked from twenty-eight to forty per cent. of the pupils aged from fourteen to eighteen. The author argues that an essential cause of obstinate headache in school children is the excessive mental

strain enforced by the present educational programme, which leaves out of consideration the peculiarities of the child's nature and the elementary principles of scientific hygiene. The overstrain brings about an increased irritability of the brain, and consecutive disturbances in the cerebral circulation. Professor Byströff emphatically insists on the imperative necessity for permanently admitting medical men to conferences of school-boards. Of palliative measures, he mentions methodical gymnastics, mild aperients in well-nourished children, steel in the anæmic, bromides, inhalation of oxygen, and, in severe cases, a temporary discontinuance of all studies.—*British Med. Jour.*

**RADICAL OPERATION FOR HERNIA.**—An improved operation for the radical cure of hernia has for some time past been practised by Drs. Svensson and Erdmann, surgeons to the Sabbatsberg Hospital at Stockholm. A ligature is applied to the neck of the hernia, and the sac is cut off below the ligature, the contents being previously examined by means of an incision into the sac and returned; or, if only omental, excised together with the sac. In congenital hernias the upper part of the sac only is removed, and where the large bowel is included in the hernia and adherent to the sac wall, this, after being separated from the surrounding tissue, is returned, together with the large intestine, and the rents of Poupart's ligament united by sutures. The dressing employed is iodoform and boracic acid; the wounds being washed with sublimate solution. Since this has been substituted for carbolic gauze, abscesses which used to occur frequently, have become rare. Of the forty-eight cases thus operated on, none of which were selected, thirty-eight were permanently cured—at least no return of the hernia occurred within six months; and in the cases where a return did take place, which amounted to 20 per cent., the condition was very much less painful and distressing than it had been previous to the operation. The Sabbatsberg Hospital has now been opened six years and a half, and during that time 300 cases of hernia have been admitted, about 200 of these being operated on with the knife; a milder procedure, consisting of alcoholic injections, being employed in most of the earlier cases. Not a single case proved fatal, though some of the hernias were very large, some reaching within three or four inches of the knee.—*Lancet.*

**BRIGHT'S DISEASE WITHOUT ALBUMINURIA.** A subject which it may be remembered, was brought prominently under notice by the late Dr. Mahomed—viz., the occurrence of renal disease without the symptom of albuminuria—was discussed by M. Dieulafoy at a meeting of the Paris Hospitals'

Medical Society on the 11th inst. (*Le Progrès Médical*, No. 25). He described four cases, which exhibited for many weeks, or even months, some of the most marked symptoms of Bright's disease, such as vomiting, oppression, headache, oedema of the ankles, the "bruit de galop," itching, *digiti mortui*, ocular and auditory derangements, and a new sign termed by M. Dieulafoy *cryæsthesia*—a sensation of extreme coldness limited to the extremities, especially the lower limbs, or to the knees. In not one of these cases was a trace of albumen found in the urine except during the last days of life. Such cases were contrasted with others of so-called "physiological albuminuria." As a means of diagnosis M. Dieulafoy suggests a test which is obviously inapplicable for clinical purposes. It is founded on Bouchard's observation that normal urine is a toxic agent to such a degree that, injected into a vein of a rabbit's ear, it will produce a fatal result when administered in the proportion of 50 cubic centimetres per kilogramme, whereas a much larger quantity (150 and even 285 cubic centimetres) of the urine of Bright's disease is required to produce the same result.—*Lancet.*

**TREATMENT OF COLLES' FRACTURE BY A NEW METHOD.**—This consists in putting up the fracture with the hand extending nearly to a right angle with the arm, and supported by a wire splint. If the forearm is placed on a flat splint so that the fingers are flexed over the end, it will be noticed that the radius does not touch the splint at all, and the ulna only on its upper third. If, however, the hand is lifted until fully extended, the radius will touch the splint at its lower end, the thenar and hypothenar eminences of the hand being lifted out of the way. The flexors act at their best advantage when the hand is thus extended, and regain flexibility and strength rapidly when the splint is removed. When the hand is clenched it moves quite perceptibly to the ulnar side of the arm. In the treatment of this fracture, the flexor muscles should be placed at their best advantage, the extensor muscles should be placed at their greatest disadvantage, and the end of the radius should be brought down upon the splint.

To accomplish these ends it is only necessary to bend a piece of ordinary telegraph wire, first into the shape of an ordinary hair-pin, then bend up sharply about two and a half inches of the closed end, flattening somewhat the top of the bend so that the fingers may rest easily upon it at their articulation with the hand. The ends of the wire are fastened with a strip of tin curved to fit the arm, and with a second strip under the end of the radius.

Dr. Keene reported three cases in which his splint fulfilled all the conditions of success, avoiding pain and swelling during treatment, and

preventing subsequent deformity and impaired function of the hand and forearm.—*Boston Med and Surg. Jour.*

**WHO GOES FIRST?**—A correspondent writes: Nothing conduces so much to absence of friction in consultations as a competent knowledge of the proper etiquette which has been handed down to us as the fruit of centuries of close observation. It is not, therefore, a useless task to attempt to define the rules of this etiquette, so that both the ordinary practitioner and the consultant may be made cognizant of the proper course to pursue, in order that the dignity of all the parties may receive the attention it deserves.

In the first place, the ordinary medical attendant should invariably lead the way, and should first enter the sick chamber, and this is a rule that for obvious reasons should admit of no relaxation.

When the interview with the patient is at an end the consultant should leave the room first, and the medical attendant should be the last to leave the room. When there are several consultants they should enter the room as stated above, but in the order in which they have been called into the case, the converse holding good for the exit.

No communication, direct or indirect, by word of mouth or by letter, should ever take place between the consultant or consultants and the friends of the patient or the patient himself, except through the intermediary of the ordinary medical attendant, and any breach of this rule should lay the consultant open to the most serious remonstrance.

The prescription should be written by the medical attendant, who, as a matter of courtesy, should precede his own initials by those of the consultant. This, however, should be done by the medical attendant himself and not by the consultant.

If these rules were duly observed, especially in the country, much of the soreness and disagreeable feeling now so common, would be obviated, and the foundation laid for more cordial relations between the consultant and his brethren in general practice.—*British Med. Jour.*

**TREATMENT OF THE HYSTERICAL ATTACK.**—Dr. Albert Ruault gives a simple method which he has found very efficacious in controlling a hysterical fit. It consists in making firm and constant pressure over the supraorbital nerve at its point of emergence from the supraorbital foramen. The head is held securely between the palms of the hands, while pressure is made over the nerve on each side with the thumbs. The writer says that the patients under this treatment first contract the facial muscles with an expression of pain, cry out, and then take several quick successive inspirations. The breath is held for a few seconds, and then, with

long expiration, the muscles relax and the attack is ended. The pressure of the thumb should now be relaxed, otherwise it may have the opposite effect and excite another convulsion. Pressure over any nerve-trunk at the point where it becomes superficial will have the same effect; but the supraorbital nerves are chosen because of their convenient situation.—(*France Medicale.*)

**RESEARCHES ON MALARIA.**—In the current number of the *Fortschritte der Medicin* there appears a translation from the Italian of some further researches on malaria by Prof. Marchiafava and Dr. Celli. The chief results so far obtained are thus summed up: (1) In the blood of individuals suffering from malaria there may be found in the interior of the red blood-discs minute organisms composed of homogeneous protoplasmic particles which are endowed with lively amœboid movements, and can be distinctly stained. These organisms are only found in the blood in cases of malaria, and are termed plasmodies or hæmoplasmodies of malaria. (2) In the interior of these units reddish or black pigment may be detected, but it is not an essential constituent, being merely derived from the hæmoglobin of the red disc. According as this pigmentation does or does not take place, we have or have not melanæmia. (3) The hæmoplasmodies may be transformed by a process of fission into a group of granules which do not possess amœboid movements. This fission may occur in the pigmented as well as in the non-pigmented plasmodies, and it is most probable that this is the ordinary mode of multiplication within the human organism. Infection may occur as the result of the intravenous injection of malarial blood, as is shown not only by clinical experience, but also by the fact that in the blood of the receiver the hæmoplasmodies may be discovered. The units further increase as infection progresses, and diminish until they disappear as infection ceases, whether naturally or under specific treatment. The authors, in determining some of the latter points, made experiments on a man aged forty-three, who was suffering from paralysis agitans, but who had never had any malarial fever. The blood was taken from a malarial subject during his apyrexial period, and the febrile movement commenced in the receiver the same evening.—(*Lancet.*)

**PAINLESS REDUCTION OF SHOULDER-DISLOCATIONS.**—Dr. Neil Macleod, of Shanghai, gives the following directions for the reduction of sub-glenoid dislocations without an anæsthetic: "Let the patient lie down on his back on the floor or ground, with the dislocated arm outstretched at right angles to the trunk, and also on the floor. Having told the patient to lie quite still and make no effort, let the surgeon, placing the approximate heel in the



axila, make traction gently and steadily at right angles to the line of the trunk; and, as there may be no jerk or evident intimation of the return of the head of the bone to its place, let him ascertain its position, if necessary, adducting the limb to make sure; if reduction have not taken place, let him renew and increase the force of traction, and repeat the examination until he has succeeded or failed, in which latter case nothing has been done to interfere with the application of other methods. It is possible that, in many cases, the heel in the axilla may be unnecessary; but it will serve to steady the scapula, and affords a better counter-extending force than the weight of the patient's body, and thus leaves him free to lie still and make no effort as if to aid."—(*Brit. Med. Jour.*)

**DIURETIC MIXTURE FOR GOUT.**—J. Mortimer Granville, in his recent work on *Gout in its Clinical Aspects*, discards the usual diuretics as irritant, the indication being to "flush" not to stimulate the kidney. For this purpose the most available drugs are ammonium chloride and potassium chlorate. At the same time the decomposition of the sodium urate in the blood may be attempted, and to this end Dr. Granville considers iodine best adapted, exhibiting it with the salts and glycerine, as exemplified in the following formula:

R. Ammonii chloridi . . . . . ℥iv,  
Potassii chloratis . . . . . ℥ij,  
Tinct. iodi . . . . . ℥cxxx,  
Glycerini . . . . . ℥iss,  
Aque . . . . . ad ℥xvj. M.

F. Mistura, cujus sumantur cochlearia duo magna quartâ quâque horâ ex aquâ.

**TREATMENT OF ACUTE TONSILLITIS.**—Dr. John Brown states, in the *British Medical Journal*, that it is a rare event for suppuration to occur in acute tonsillitis, if treated early with the following mixture:

R. Sodii salicylat., . . . . . ℥ iss.  
Pot. bicarb., . . . . . ℥ iss.  
Tinct. aconit., . . . . . ℥ 40.  
Liq. opii sed., . . . . . ℥ 30.  
Sp. chloroform., . . . . . ℥ ii.  
Aq. ad. . . . . ℥ viii. M.

One ounce to be taken every two or three hours for the first thirty-six hours. The same mixture is his sheet anchor for rheumatic fever.

**SUMMARY OF PASTEUR'S WORK.**—Up to April 14th, Pasteur had inoculated 688 persons, presumably bitten by mad dogs, with only one death. He had also inoculated 19 Russians bitten by a mad wolf. Of these nineteen, three have died from hydrophobia—about sixteen per cent. The usual per cent. of deaths from the bites of mad wolves is said to be about sixty-seven. Since

April 14th, Pasteur has treated other Russians bitten by mad wolves and mad dogs. One of the former recently died from the effects of his wounds; one of the latter from hydrophobia, after having been submitted to treatment. This makes in all 720 cases treated, with a total of five deaths from rabies, despite treatment. Pasteur has found that the rabies resulting from wolf bites is the same as that of dogs, and only more dangerous, because the bites of wolves are more numerous and severe.—*Med. Record.*

**LOCAL REMEDY FOR NEURALGIA.**—A mixture of one part of iodoform to ten or fifteen of collodion, if spread repeatedly upon a neuralgic surface until it attains a thickness of one to two millimetres, is said to be quite effective in the treatment of certain neuralgias. If the first application does not speedily terminate the neuralgia, those who have used this mode of treatment direct that its application should be continued. It seems especially valuable in the relief of trigeminus. It also seems of value to be applied along the spine, particularly at painful points in what is called spinal irritation. These observations are by no means new, and yet they seem worthy of further consideration.—*Neurological Review.*

**ACETATE OF COPPER IN THE TREATMENT OF SCROFULA AND TUBERCULOSIS.**—Luton (*Journal de Méd. de Paris*), has used this drug quite extensively, both externally and internally, and speaks highly of it. In treating old suppurating glands, he uses an ointment containing one part of the neutral acetate to thirty parts of ointment. Rapid healing occurs. He administers to phthisical patients the following dose every evening:

Acetate of copper . . . . . 3-20 grain.  
Extract opium . . . . . ½ grain.

The dose of copper may be gradually increased to three fourths of a grain.—*N. Y. Med. Jour.*

**CATARHAL HEADACHE.**—Iodide of potassium is said to quickly relieve the dull headache so often accompanying an ordinary cold in the head. Two grains may be dissolved in a glass full of water, which is to be taken in little sips during half an hour. Dr. Davis recommends this simple remedy, and says he has hardly every known it to fail.

**TRANSPLANTATION OF THE TENDON OF A DOG TO MAN.**—M. Peyrot, at the meeting of the Paris Société de Chirurgie, May 5th, reported a case in which retraction made it impossible to suture the divided ends of the medius. He removed a piece of tendon from a living dog and sewed it to the divided tendon. The result was successful, functionally as well as anatomically.

# THE CANADA LANCET.

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Criticism and News**

*Communications solicited on all Medical and Scientific subjects, and also Reports of Cases occurring in practice. Advertisements inserted on the most liberal terms. All Letters and Communications to be addressed to the "Editor Canada Lancet, Toronto."*

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## ACUPUNCTURE.

The operation of acupuncture for the relief of the pain of chronic rheumatism, lumbago, sciatica, etc., dates back for ages. It was, hundreds of years ago, a stock operation with the Orientals, who often produced wonderful results by it. The Chinese and Japanese practise it largely to this day, and there is no doubt their success is often marvellous. English and American surgeons have not been able to obtain very favorable results from the operation, or at least the results have been at all times looked upon as being very uncertain. In a majority of properly selected cases the effects are prompt, and the patient is both bewildered and delighted at the relief he has obtained from pain and disability, by so simple means. But owing to the fact that explanation of the cause of cure, when it does occur, is difficult, if not impossible, and that failure is not improbable, it is not much practised by English-speaking surgeons. No doubt there are many practitioners in this country who have never done the operation, or have never seen it done, and yet it is so simple of performance, and the relief so immediate when it is obtained at all, that we think it might be practised more frequently, with profit to a considerable class of patients. That terrible enemy to rest and comfort, sciatica, is unfortunately least amenable to treatment by this method, failure being more frequent than in lumbago or chronic rheumatism, but we have seen a patient with sciatica rise up and look as if he wished to call the operator blessed after five minutes with the

needles. The relief here is seldom permanent, usually lasting from a few moments to an hour. It is mostly of service in rheumatism of the muscles, of a chronic character, being contra-indicated when there is much redness, swelling or heat of the affected part. It is perhaps in lumbago that the success of acupuncture is most signal: a patient being relieved at once of all muscular disability and pain, by the introduction of two needles, one on each side of the spine to the depth of an inch or so.

The atrophy, due to impaired nutrition of muscular tissues whose fasciæ and aponeuroses are affected, generally disappears when pain and disability are relieved. Pain is not so often cured as muscular disability. The needles should be flexible, at least two inches long, either round or cutting-edged, and of the size of a medium-sized darning-needle. Indeed the operator may easily improvise capital instruments, by moulding handles of sealing wax, upon half a dozen ordinary darning-needles. The needle is dipped in some antiseptic solution, such as carbolic oil (1 in 40) and then introduced with a rotary motion, deeply into the tissues, even till it touches the bone. The region of greatest disability, pain, or tenderness is chosen for the points of puncture, and the needles are left in from two to ten minutes. Sometimes the effect is magical, the pain ceasing on the introduction of the needles but oftener in successful cases there is a decrease in the symptoms for some minutes, and in entirely successful cases the relief is soon complete.

It is said that when the action of the needles is beneficial, a red areola, from one to two inches in diameter is observed around each point of puncture, and that the appearance of this areola is in direct proportion to the success of the operation. This is not always true, for we have seen cases in which a very considerable amount of improvement took place, with no such areola perceptible. The number of needles need not be limited, for it is believed that the success of their action depends more upon their number than upon the length of time they are left in. In those forms of myalgia left after injury to a joint, relief is very frequently found from acupuncture, though metastasis may occur, and the pain may pass to the similar situation on the opposite side of the body. If there be extensive muscular atrophy, galvano-puncture

sometimes succeeds when acupuncture fails. Though it is in lumbago that acupuncture finds its most successful application, it will prove unsuccessful when high fever accompanies it, or when pain in the back happens to be the first symptom of an attack of acute rheumatism. When the lumbago is accompanied with sciatica or neuralgic pains, the lumbago may be cured, but the sciatica or neuralgia will remain, and when this is cured says Ringer, the lumbago will be found to have returned.

As regards the explanation of the cause of cure, various views have been advanced. Sir Joseph Fayrer suggests that the success may be due to relief of tension caused by accumulation of fluid round the large and small nerve trunks, under the influence of inflammation. He cites a case in which evacuation of a couple of drachms of clear serous fluid from the sheath of the sciatic nerve gave instant relief, and was followed by complete recovery from an aggravated attack of sciatica. He was led to puncture the nerve sheath by making out fluctuation in its course. Mr. Teale, of Leeds, thinks the pain is relieved by increasing the nutrition of the nerves of the part, which is accomplished by a flushing or congestion of the vasa nervorum of the area of pain. The muscular fibres are also wasted from want of proper action, the arteries become lessened in calibre from an insufficient quantity of blood, and from the decreased call for nutrition to the parts at rest. This insufficient supply of blood is remedied by the needle producing a temporary congestion, and increased blood supply.

However the result may be brought about it is certain that many cases now untreated or treated by less successful methods, would benefit by the application of the needle, and we call attention to the subject in the hope that it may receive more attention from members of the profession than it has in the past

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#### FOOD, ITS QUANTITY AND QUALITY.

The connection between life and nutrition is so close and inseparable, that the continuance of the former depends upon the supply of the latter. The variation and form of life, whether animal or vegetable, depends upon the quantity and quality of nutrition with which it is supplied.

We are readily able to judge of the quantity and quality of nourishment supplied to a vegetable that we are caring for and will at once decide whether the supply is normal, insufficient or in excess of the nutrition necessary. Every living organism demands its own peculiar supply designed for it by the laws of nature. When the natural supply is normal in all respects, the life is healthy. The same law holds good in the higher order of life that we observe in the lower. Insufficient alimentation in the vegetable kingdom is followed by consequences which we are not liable to misunderstand. There is loss of health and vigor, a gradual shrinking, and if the process is permitted to go on, death occurs. A great excess of even the natural nutrition tends to the same result. A marked departure in either direction from the normal standard of supply will, with very few exceptions, be followed by a marked departure from the normal standard of life.

In man the effect of over-eating or under-eating is not so observable, owing to the more complex nature, still the same rule doubtless holds good. It is needless to mention that brutes suffer from improper feeding and particularly over-feeding. Excessive alimentation in the human being is followed by the same baneful consequences. Is it not a fact that the generality of people eat too much? Very few eat too little. It is a common-place aphorism, "He eats so much that it makes him poor to carry it." As a rule, a large, lean, cadaverous-looking man, is an immoderate eater, whilst the majority of our robust and healthy are moderate consumers of food, or are what we call small eaters. The reason of this is plain. He who eats more than is demanded by nature, imposes a heavy strain on the organs involved in the process of digestion and elimination. The stomach, for instance, is capable of doing a certain amount of work, hence if overtaxed unduly, the result sooner or later will be imperfect digestion, disordered functions, and gradual loss of vigor and strength. As certain as we overstep the bounds of nature and overtax our stomachs for our palate's sake, we begin to sow the seed of disease. Certainly the stomach is a remarkable organ, and able to resist the assaults of imprudence with wonderful courage, but its power of endurance

will not withstand every imposition heaped upon it, and sooner or later it will succumb to the force of unrelenting overwork.

The physician should be as careful in regard to the treatment of over-fed and under-fed patients, as in the quantity and kind of medicine used in the treatment of a special disease. It is too common an error, when we see patients emaciated, to advise abundance of nourishing food, while probably it is a well-laden table that is at the foundation of the condition sought to be relieved. There is far more danger from over-indulgence than under eating. Although we desire to impress the fact that over-eating is common and should be strictly guarded against, we are not unaware of the existence of under-fed or half starved people, but this is by no means as common an evil, and very little disease is traceable thereto.

**QUEBEC MEDICAL EXAMINATIONS.**—The following amendments to the Quebec Medical Act were lately adopted by the College of Physicians and Surgeons of that Province—The Central Board of Examiners shall consist of two examiners on each subject, one English and the other French. The examinations shall be made in the candidate's language, each examiner having the right to examine alternately. The Board of Examiners shall consist of two representatives from each medical school. Examinations shall commence the second Tuesday in April at Montreal or Quebec, as may be decided by a by-law, and shall be written and oral. Preliminary examinations shall be held on the first Wednesday in July, at Quebec and Montreal alternately. The fees are as follows:—For the preliminary examination, \$16; for the final examination, \$10; for diploma of membership, \$25.

**CREOSOTE A SPECIFIC IN ERYSIPELAS.**—A writer in the *St. Louis Med. Jour.* speaks highly of the value of creosote in erysipelas. After an experience of forty years, this practitioner has laid aside all other remedies and uses this one "with uniform success." He claims that when injuries, of whatever kind, are healed with a solution of from six to twenty drops to the ounce of water, erysipelas never occurs. The parts should be kept constantly wet with this solution. Ulcers and wounds

may be treated with a poultice, made by stirring ground elm into the solution.

**THE ACTION OF CHLORATE OF POTASH.**—After careful experiments with chlorate of potash, Dr. Von Merting has arrived at the following conclusion regarding its action and use: First, the salt should be given after meals; second, quite an interval should occur between the doses; third, it should not be administered in high fever on account of the diminished alkalinity of the blood; fourth, it is contra-indicated in emphysema, dyspnoea, renal disease, etc.

The *Lancet* says that it is found from the careful investigations of Dr. Ablestoft, that hydrochlorate of pilocarpine is not only useless, but often positively harmful in the sweat of phthisical patients. It is useful as an expectorant, but not more so than other remedies whose effects in other respects are not so injurious. Agaracin and homatropin are recommended as the most useful remedies in phthisical sweats.

**CALOMEL AND BROMIDE OF POTASSIUM ARE INCOMPATIBLE.**—It is remarked that calomel is decomposed on the addition of potassium bromide, although more slowly than when the iodide is added. The two drugs, therefore, should not be given closer than five or six hours of each other. The two drugs may in cases of infantile convulsions, be inadvertently given nearly at the same time.

**TURPENTINE IN OLD SINUSES.**—Cecchini (*Annali Universali di Medicina*) says he has succeeded in closing several anal fistule and sinuses by the injection of a few drops of oil of turpentine, with a hypodermic syringe. The drug may be used pure and then with the best results, but the addition of some simple oil or morphia lessens the pain, which is sometimes considerable. He considers the turpentine acts as a simple stimulant, favoring the formation of healthy granulations.

**TREATMENT OF FRACTURED THIGH IN INFANTS.**—Surgeons in treating these fractures, should be particularly cautious, should they use extension by means of a weight and pulley, to not put on too heavy a weight, as a considerable harm may be done by stretching the ligaments at the knee joint, which is easily done.

**TO PREVENT MAMMARY ABSCESS.**—Mr. Miall (*Brit. Med. Journal*) says that when mammary abscess is on the point of forming, he has frequently seen all the symptoms rapidly disappear in a few hours, under the influence of fomentations with hot water and carbonate of ammonia. He uses an ounce of the carbonate in a pint of water, and when solution is accomplished the temperature of the fluid will be hardly too high for fomentation to be commenced, with cloths dipped in the liquid. He applies them for from half an hour to two hours, at the same time protecting the nipples. He has often had immediate relief, and seldom requires to make more than three applications.

**FORMULA FOR USE IN EPILEPSY.**—The following is said (*Med. Press and Circular*) to be beneficial in epilepsy, without producing the bad effects witnessed from the continued use of bromide of potassium.

R. Ammon. brom. . . . .  $\bar{3}$  iiss.  
 Syr. Limonis . . . . .  $\bar{3}$  iii.  
 Aq. . . . . ad  $\bar{5}$  x. M.  
 S.  $\bar{3}$  ss. four times a day in infusion of valerian.

**TEMPERATURE OF THE MAMMARY GLAND DURING THE PUERPERIUM.**—Negri gives an abstract of investigations of a number of cases of the above. He finds that the temperature of the gland is higher after delivery than during pregnancy or the non-pregnant state, though usually not so high as the axilla. 98.5 F. was rarely exceeded. The more copious the secretion of milk, the higher was the temperature.

**PAINFUL DENTITION.**—The following is said (*L'Union Medicale*) to be an excellent preparation in painful dentition.

Cocaine hydrochlorate.  
 Sodium borate, . . . . . aa. gr. iv.  
 Syrup of althaea . . . . . ℥. 64.  
 Syrup of poppy to make . . . ℥. 100.

A little to be rubbed on the gums several times a day.

**PERMANENT DRAINAGE IN ASCITES.**—Dr. Caillé lately inserted a short drainage tube into the abdomen of a man, who had been tapped nine times, and applied antiseptic dressings. Two or three pints of fluid were at first evacuated, which quantity gradually diminished, with great amelior-

ation of all the symptoms. The patient lived and worked with comfort for nine months, finally dying of heart failure.

**QUININE AS AN OXYTIC.** Drs. Coe and Allen find (*Atlanta Med. and Surg. Journal*) that quinine in doses of ten grains and upwards increases the force of the contractions of the uterus during labor, though it has no effect in initiating contractions in the pregnant or non-pregnant uterus.

**SNUFFS FOR CORYZA.**—Rabon (*Deutsche Med. Wochen.*) recommends the following powders to be used as snuff in coryza.

1. Menthol, 2 parts; roasted coffee, 50 parts; white sugar, 50 parts; mix, and take as snuff.
2. Cocaine hydrochlorate, 1 part; roasted coffee and white sugar, of each 50 parts; mix, and use as before.

**APPOINTMENTS.**—Dr. N. J. Tucker, of Manitowaning, and Dr. N. A. Powell, of Toronto, to be associate coroners for Algoma and York respectively.

Drs. Graham and Teskey have been appointed to the staff of Toronto General Hospital, and Drs. W. H. B. Aikins and J. L. Davison as pathologists.

**PERSONAL.**—Dr. J. W. Rosebrugh, of Hamilton, sailed last week for Europe. The Doctor goes as a delegate from the Ontario Medical Association to the British Medical Association. He will also attend the annual meeting of the British Gynaecological Society, of which he was recently elected a Fellow.

**BEEF-TEA.**—Fothergill stated some time ago that beef-tea is rather a stimulant than a nourishment, and now an article appears in the *Nineteenth Century*, showing that it powerfully retards digestion. This action is said to be due to the organic acids contained in it.

**HYPERIDROSIS OF THE FEET.**—In cases of undue sweating of the feet, accompanied by soreness and whitening of the skin of the sole, a cure may be readily affected by the application, once a day, of equal parts of citrine ointment and ung. aq. rosæ. The feet should be bathed frequently.

LEUCORRHOEA AND FŒTID VAGINAL DISCHARGES.

—The following injection is recommended in an exchange: Chlorate of potash,  $\bar{5}$ iii; laudanum,  $\bar{5}$ ii; aqua rhenicæ,  $\bar{3}$ x. Two or three tablespoonfuls to a quart of warm water.

URTICARIA AND PRURITUS.—Menthol is said to relieve the itching and cure the disease. In pruritus ani, and in eczema, the parts should be moistened with menthol solution, containing from five to ten grains of menthol to the ounce of water.

DR. F. N. OTIS, of New York, argues in an article before us that there is a positive limitation to the contagious stage of syphilis within three or at furthest four years, with or without treatment. This assertion can not but excite considerable attention.

TO KEEP OFF MOSQUITOES:—

R    Camph. (pulv.) . . . .  $\bar{5}$ i  
       Spt. Vin. Rect. . . . .  $\bar{5}$ i  
       Ol. Oliv. . . . .  $\bar{5}$ i    M.  
 S.    Apply to exposed parts.    —

SORE NIPPLES.—The following will be found useful for sore nipples:

R.    Acidi Sulphurici  
       Glycerini                    P. Æ. M.  
 Sig.—Apply frequently

A WRITER to the *British Medical Journal* reports two cases of symptoms of poisoning from the administration of half tea-spoonfuls of vaseline, given on sugar, for sore throat.

PARALDEHYDE, AN ANTIDOTE TO STRYCHNINE.—Dujardin Beaumetz recommends from  $1\frac{1}{2}$  to 2 grains of paraldehyde as an antidote to strychnine.

ANTIDOTE TO COCAINE.—It is said that inhalations of nitrite of amyl will restore to consciousness persons poisoned by cocaine.

ERRATUM.—In Medico's letter, on page 322 of July LANCET, line eight from bottom "No. One's" should read "No. Two's."

SINGLUTUS.—It is said that a pinch or two of "catarrh snuff," will, by inducing immoderate sneezing, cure any case of hiccuph.

Will the gentleman who remitted \$6 subscription to the LANCET, signed "Morrisburgh," please send his name to the editor.

Notes, Queries and Replies.

Will some one of the correspondents of the CANADA LANCET be good enough to explain why, in the application of the forceps, the lower blade should be introduced first. The text books all say they should be so applied, but why, is a puzzle to me. It has always seemed to me that much that is written on this subject only serves to confuse the novice, and that older practitioners rely on common sense in the adjustment of the forceps, rather than upon fixed rules.

ENQUIRER.

Books and Pamphlets.

BRAIN REST. Second Edition. By J. Leonard Corning, M.D. G. Putnam's Sons, New York. Williamson & Co., Toronto.

This little duodecimo of 135 pages contains some interesting matter on the important subject chosen as its title. The reader must not be alarmed by the formidable caudal appendages to his name, exhibited by the author on the title page, covering eleven lines of small capitals. He will find in the book some very useful hints on sleep and sleeplessness which he may peruse without becoming drowsy. Cerebral hyperemia and anæmia are treated of with commendable brevity and clearness. The chapter on "*the mechanical regulation of the cerebral circulation*," should be carefully studied. Perhaps the reader may question the efficiency of Dr. Corning's method of lessening blood flow into the brain, by compression of the two common carotids; for as these vessels are not only in close proximity to the internal jugulars, but also are lodged in company with these veins and the pneumogastric nerves, in pretty strong sheaths, it may be questioned whether the carotids can be effectually compressed without the jugulars sharing in the process; and if so, what can be gained by a compression which must obstruct the flow from the brain as much as it does the flow into it, or indeed move, for the vein is more compressible than the artery.

THE METHODS OF BACTERIAL INVESTIGATION. By Ferdinand Hueppe. Translated by M. Biggs, M.D. Illustrated by 31 wood-cuts. New York: D. Appleton & Co.

The subject of bacteria and their intimate con-

nection, whether causally or resultively, with many diseases, have now become of such great interest to the medical profession, that no member of it who desires to maintain a respectable position in its ranks, can afford to remain in the rear of the grand crusade. The book treats of the various forms of bacteria and the medical technique, the culture methods, inoculation processes, general biological problems, special hygienic investigations, and finally : bacteriology as an object of instruction. Under each of the preceding heads the reader will find instruction of great value, conveyed, as usual in all German treatises, with all desirable minuteness of detail, and it is to be hoped that the work will be attentively studied by a large number of patrons. We congratulate Dr. Biggs on his successful re-production of the work in English.

**MEDICAL PHYSICS BY DRAPER.** Philadelphia : Lea Bros. & Co.

The bare name of the author of this work is an ample guarantee for its excellence and its high utility. By the student who has not had the advantage of a university training, or the benefits of a full course in technology, Prof. Draper's book should be held as altogether indispensable ; nor can its contents fail to be appreciated by physicians whose acquaintance with the sciences akin to medicine has been of even exalted order. It deals with *matter* in all its forms, properties and activities. It cannot be regarded as a work profitable to the medical profession alone, for it conveys instruction which is needed by every reputable member of society, but more especially by those engaged in educational work. In truth it fills a blank that has too long existed in the literature of science, and its appearance at this time confers honor on the publishing house which has issued it in such prepossessing form. It is illustrated by no less than 377 finely executed wood-cuts, and it covers in all 733 pages.

**A MANUAL OF SURGERY.** In Treatises by Various Authors. In three volumes, edited by Frederick Treves, F.R.C.S., Surgeon to and Lecturer on Anatomy at the London Hospital. Duodecimos, 1866 pages, 213 engravings. Per volume, cloth, \$2. Philadelphia : Lea Brothers & Co., 1886.

These volumes form part of a series of manuals for students of medicine. Their size renders them convenient pocket companions. The editor though

a young man, has made a place for himself among the most eminent British surgeons of our day. The work deals with the general principles of operative surgery, but details are omitted except in special operations such as tracheotomy, gastro-tomy, ovariectomy, etc. The articles are written by the best known men in Britain, and are admirably adapted for the use of students, while they will also be valuable as short guides to practitioners desirous of getting the latest ideas of surgery as practised in England. We heartily recommend the work to students and practitioners.

**A MANUAL OF PRACTICAL THERAPEUTICS.** By Edward John Waring, C.I.E., M.D., etc., etc. Edited by Dudley W. Buxton, M.D., B.S., Lond., etc., etc., 4th Ed. Philadelphia : P. Blakiston Son & Co. Toronto : Hart & Co.

This work has been largely re-written and brought up to the present time. The contents are concisely arrayed, many minor articles mentioned in the other editions are omitted, and the principal changes made in the last pharmacopœia are incorporated. New remedies receive due attention, and the amount of labor shown by the author and editor leads the reader to the conclusion that he is getting a digest of the best medical thought of the day, in regard to the action of the various remedies under consideration. The book will be a valuable addition to the library of the practitioner.

**ANALYSIS OF THE URINE.** By Prof. Hofman, of Gratz, and R. Ultzman, Vienna. Translated by T. Barton Brune, A.M., M.D., and H. Holbrook Coates. New York : D. Appleton & Co. Toronto : Williamson & Co.

The second edition of this classical work on the urine will be welcomed as containing all the latest advances in urinary analysis. All unnecessary matter has been eliminated, and the chemistry is so simple as to be within the comprehension of all. The translators have made a few additions which are practical and therefore useful.

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### **Births, Marriages and Deaths.**

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At Ingersoll, on July 14th, J. McWilliam, M.D., to Jessie B., eldest daughter of the late G. B. Petrie Esq., Thamesford.



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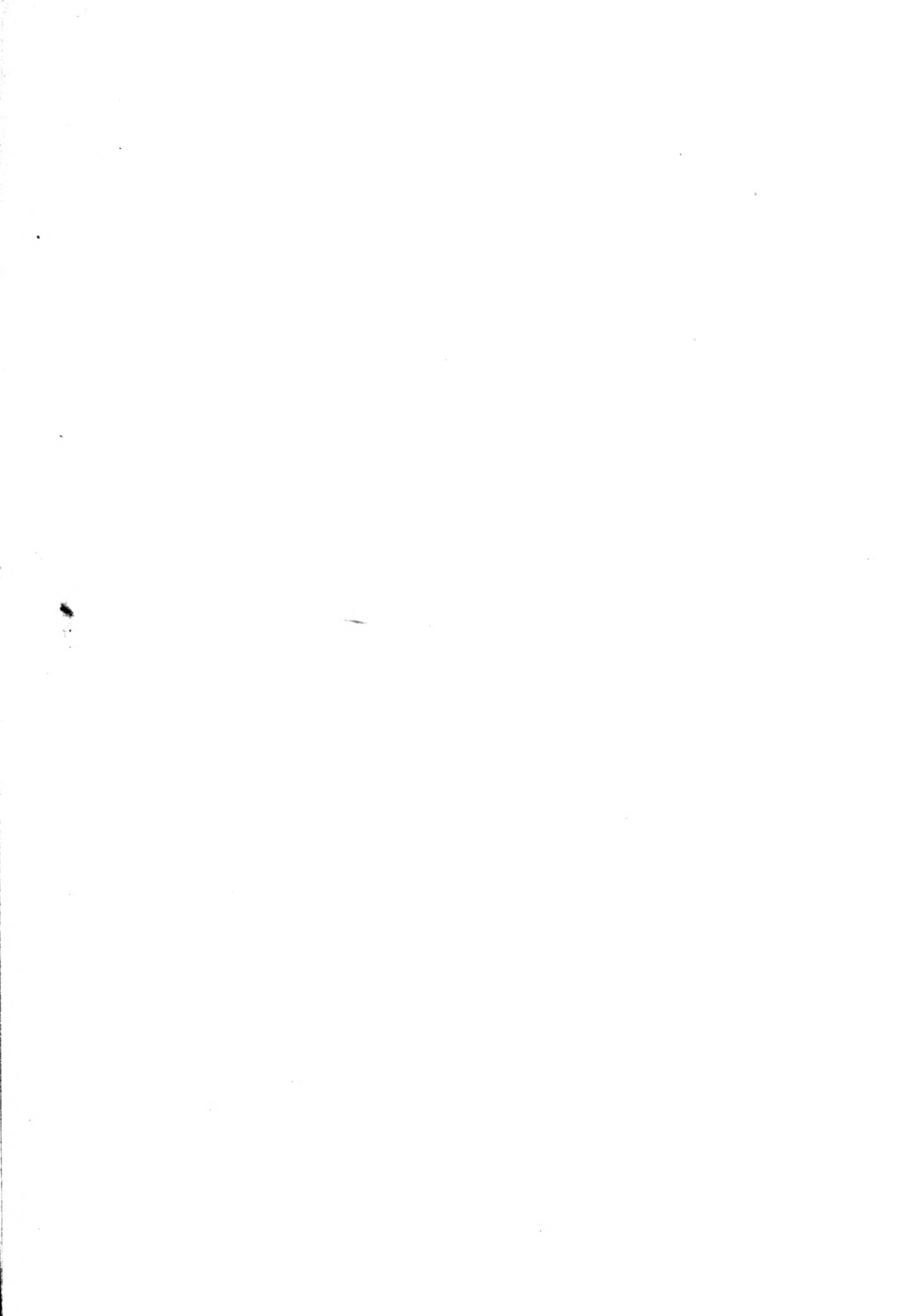
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